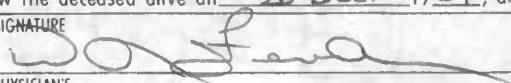
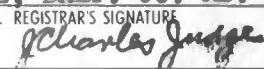


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

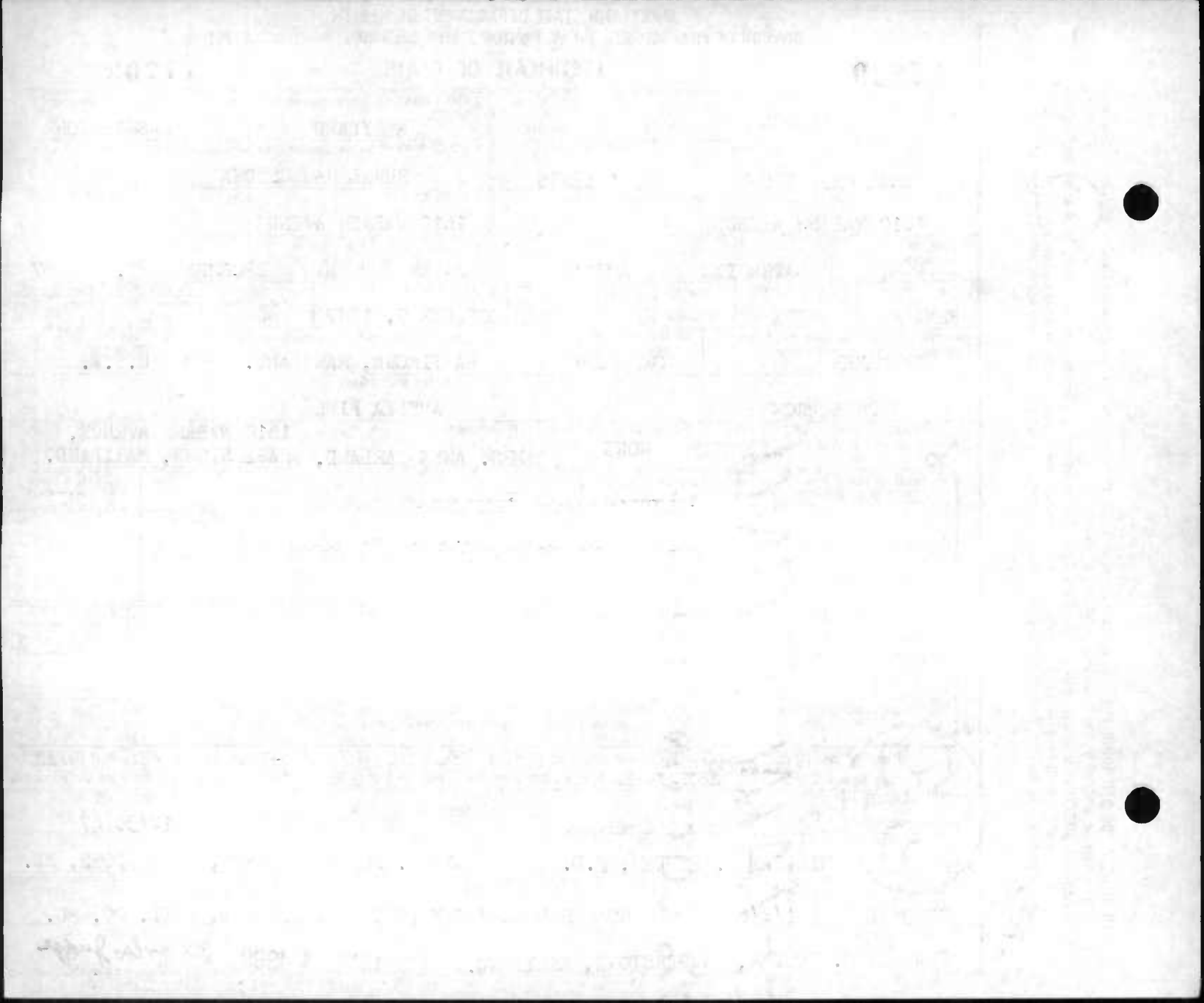
CERTIFICATE OF DEATH

17699

17702

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN c. LENGTH OF STAY IN 1b 5 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1610 WABASH AVENUE				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN d. STREET ADDRESS 1610 WABASH AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE AMELIA BAUER			4. DATE OF DEATH Month Day Year DECEMBER 29, 1967				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH OCTOBER 7, 1887		9. AGE (In years last birthday) yrs. 80		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND.			
13. FATHER'S NAME GEORGE BROWN			14. MOTHER'S MAIDEN NAME AMELIA FINK				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. ANNE GARLAND, 1610 WABASH AVENUE, HAGERSTOWN, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH Minutes Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 8 March, 1963 , to 29 Dec, 1967 , that (I) X saw the deceased alive on 20 DEC. 1967 , and that death occurred at 4:30 P.M. , from causes and on the date stated above.					
22a. SIGNATURE 				22b. DATE SIGNED 12/30/67			
22c. PHYSICIAN'S NAME (Type) WILLIAM N. FENDER, M.D.				22d. ADDRESS 218 N. POTOMAC STREET, HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 1/2/68		23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY			
23d. LOCATION (City or Town) (County) (State) BALTIMORE, BALT. CO. MD.		24. FUNERAL DIRECTOR ADDRESS CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.					
25a. REC'D BY REGISTRAR DATE JA 4 1968				25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

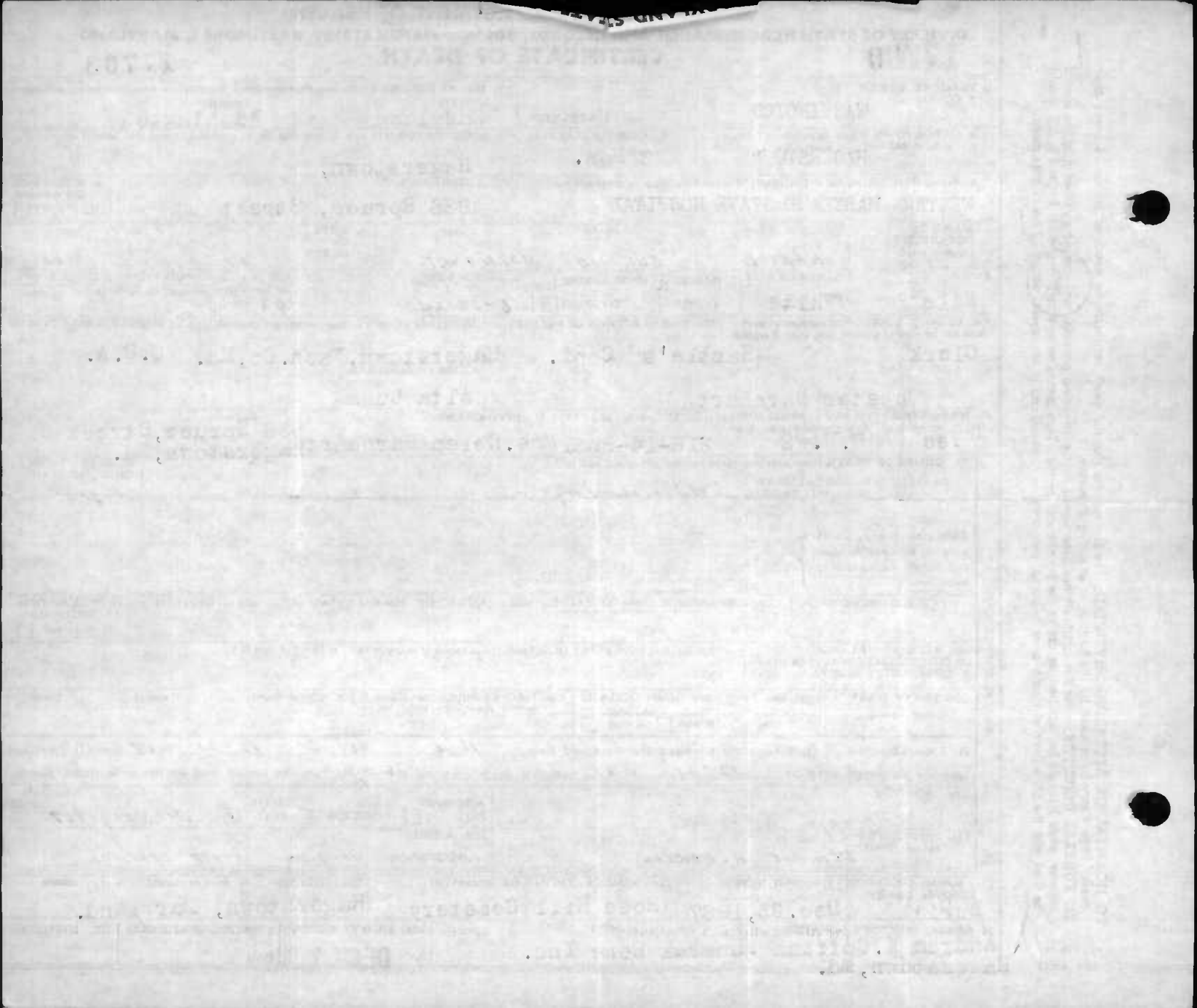
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

17700

17703

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 2 Mon.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				d. STREET ADDRESS Hagerstown, 836 Spruce, Street			
3. NAME OF DECEASED (Type or print) First HAROLD Middle EUGENE Last BARNHART				4. DATE OF DEATH Month December Day 21 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-22-24	
9. AGE (In years last birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 43 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Hartle's Conf.			
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Wash. Co., Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lester Barnhart				14. MOTHER'S MAIDEN NAME Alta Lumm			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W.#3 216-14-5581			
17. INFORMANT Mrs. Helen Barnhart				Address 836 Spruce, Street Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO 203x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 203x DUE TO (c) 203x PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 203x							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-6-67 , to 12-21-67 , that (I) (we) last saw the deceased alive on 12-21-67 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Domingo X. Garcia M.D.				22b. DATE SIGNED Dec. 21, 1967			
22c. PHYSICIAN'S NAME (Type) DOMINGO A. GARCIA				22d. ADDRESS WESTERN MARYLAND STATE HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 23, 1967		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman ADDRESS Hagerstown, Md.				25a. REC'D BY REGISTRAR DEC 27 1967 25b. REGISTRAR'S SIGNATURE William A. Vande...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>Items 18&21 Film 396</div> <div>12-21-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>17701</div> <div>CERTIFICATE OF DEATH</div> <div>17704</div>											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 17 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1041 Bramley Drive						d. STREET ADDRESS 1041 Bramley Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FLORENCE BUTCHER BECHTER						4. DATE OF DEATH Month Day Year Dec 10 1967 19					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 27 1888		9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) N.J. Haddonfield Camden Co				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry B. Butcher						14. MOTHER'S MAIDEN NAME Harriett Taylor					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Charles A. Bechter 1041 Bramley Dr					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure due to ingestion of sodium amytal 970.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Arteriosclerotic heart disease with enlarged heart and congestive failure										INTERVAL BETWEEN ONSET AND DEATH Uncertain Between 12 Noon-4 PM 12/10/67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease with enlarged heart and congestive failure											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 8 , 1967, to Dec. 10 , 1967, that he (we) lost the deceased alive on Dec. 10 , 1967, and that death occurred at 4P. M, from causes and on the date stated above.											
22a. SIGNATURE B. B. Kneisley						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/11/67			
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.						22d. ADDRESS 148 West Washington St. Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/13/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery				23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md			
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc						25a. REC'D BY REGISTRAR DEC 14 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 60 YRS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		d. STREET ADDRESS 245 S. POTOMAC ST.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LOTTIE Middle MAE Last BERGER		4. DATE OF DEATH Month DECEMBER Day 29 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/1879
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADOLPHUS POTTS		14. MOTHER'S MAIDEN NAME SARAH CATHERINE WORLEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. FRANCES NEWCOMER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vascular accident probably myocardial infarct DUE TO (b) Generalized arteriosclerosis DUE TO (c) indef		INTERVAL BETWEEN ONSET AND DEATH 5 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cystitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 , 19 52 , to death 19 67 , that (I) (we) last saw the deceased alive on 12-29 19 67 , and that death occurred at 6 P M, from causes and on the date stated above.			
22a. SIGNATURE Robert F. Keodk		22b. DATE SIGNED 12-30-67	
22c. PHYSICIAN'S NAME (Type) Robert F. Keodk		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Type) BURIAL		23b. DATE THEREOF 1/1/68	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD	
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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NOTED ON 10/10/50

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[Faint, mostly illegible handwritten notes and signatures covering the lower half of the page.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 17703. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>				d. STREET ADDRESS <u>BOX 316 RTE 16</u>			
3. NAME OF DECEASED (Type or print) First <u>ROLS</u> Middle <u>W.</u> Last <u>BOLLING</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 14, 1888</u>		9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS BOLLING</u>				14. MOTHER'S MAIDEN NAME <u>MARY REILEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>213-12-4375</u>		17. INFORMANT <u>WM. BOLLING</u>		Address <u>RANDALSTOWN</u> <u>5111 OLD COURT RD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Lobular Pneumonia</u> DUE TO <u>Secondary to -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Pathological Fracture Right Femur due</u> DUE TO <u>Metastatic Malignancy of Unknown Site</u> (c) <u>Prostate Prostate</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Edward W. Dittolli</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DR. E. W. DITTO</u>		22. DATE SIGNED <u>12-3-67</u>		23. ADDRESS (Street, city, town, or county) <u>217 W. WASHINGTON ST., HAGERSTOWN, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EBENIZER CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR <u>Crunelly Funeral Home</u>				ADDRESS <u>300 Maryland St.</u>		25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. Va. b. COUNTY Hefferson	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b Williamsport	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Homewood Church Home		d. STREET ADDRESS Kearneysville	
3. NAME OF DECEASED (Type or print) First Annie Middle Etheridge Last Border		4. DATE OF DEATH Month December Day 9 Year 19 67	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1882
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 5 Days 7 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY housewife	
11. BIRTHPLACE (State or foreign country) Galveston, Texas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Shadrach Etheridge		14. MOTHER'S MAIDEN NAME Annie Lobert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. S. Carlton Sykes, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Cerebral Pneumonia DUE TO Secondary to: DUE TO Fracture Femur Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized Arteriosclerotic heart Dis	
19. INTERVAL BETWEEN ONSET AND DEATH 5-7 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slid off bed - Fractured Femur	
20c. TIME OF INJURY Month, Day, Year 10 p.m. Oct 25, 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) old folks home		20f. (City or town) (County) (State) Williamsport Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Edward W. Ditto III		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12-12-67	
23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		23d. LOCATION (City or Town) (County) (State) Shepherdstown, W. Va.	
24. ELIMINATED BY REGISTRAR E. Gray Davis		25a. REC'D BY REGISTRAR DEC 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE SIGNED 12/9/67	

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Department

Division

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Dec 2, 1952

USA, Texas, Houston

Mr. Robert

Mr. Robert

Mr. Robert, Houston, Texas

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Mr. Robert, Houston, Texas

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17705

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17708

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>3 mos - 3 weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		21.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Sanitarium</u>		d. STREET ADDRESS <u>Rockcliff Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Mary</u> Last <u>Botto</u>		4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1882</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Clinton Co, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eli Shilling</u>		14. MOTHER'S MAIDEN NAME <u>Katherine BANEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-09-6106</u>	
17. INFORMANT (Son) <u>Harry E. Botto Jr.</u> Address <u>Rockcliff Drive, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart failure</u> DUE TO (b) <u>Atherosclerotic cardiovascular disease 10 yrs?</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1967</u> to <u>Dec 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-15-1967</u> and that death occurred at <u>4 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Byrkit</u>		22b. DATE SIGNED <u>12-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		22d. ADDRESS <u>Williamsport Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12/11/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>HAGERSTOWN, WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR <u>CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.</u>		25a. REC'D BY REGISTRAR <u>DEC 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 40 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL						d. STREET ADDRESS 125 WEST SIDE AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JEAN Middle RINGEL Last BREITWEISER						4. DATE OF DEATH Month DECEMBER Day 19 Year 1967					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 2/18/1897		9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES CRAIG						14. MOTHER'S MAIDEN NAME ELLA MORCRET					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-20-1663D		17. INFORMANT MRS. MARY JANE HUFFER				Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1955 , 19 to 12/19/67 , that (I) (we) last saw the deceased alive on 12/19/67 , and that death occurred at 1:00 p.m. M, from causes and on the date stated above.											
22a. SIGNATURE W.C. Breuer						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/20/67			
22c. PHYSICIAN'S NAME (Type) W.C. Breuer, M.D.						22d. ADDRESS Greencastle, Pa.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/22/67		23c. NAME OF CEMETERY OR CREMATORY GREEN HILL CEM.				23d. LOCATION (City or Town) (County) (State) WAYNESBORO PENNA.			
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.						25a. REC'D BY REGISTRAR DEC 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17707

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 128 Conococheague St.					
3. NAME OF DECEASED (Type or print) First Howard Middle Ray Last Burger				4. DATE OF DEATH Month Dec. Day 10 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 23 1891			
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 3 Days 16 Hours Min. 		IF UNDER 24 HRS. Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Weaver				10b. KIND OF BUSINESS OR INDUSTRY Textile Mill		11. BIRTHPLACE (County & State, or foreign country) Hagerstown Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A									
13. FATHER'S NAME Augustus Burger				14. MOTHER'S MAIDEN NAME Henrietta Rider					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 217-01-4855		17. INFORMANT 128 Conococheague St. Mrs. Lillie Burger Williamsport Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis left femoral artery								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 11-4 , 19 67 , to 11-10 , 19 67 , that (I) (we) last saw the deceased alive on 11-10 , 19 67 , and that death occurred at M, from causes and on the date stated above.									
22a. SIGNATURE M.E. Byrkit				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-11-67			
22c. PHYSICIAN'S NAME (Type) M.E. Byrkit M.D.				22d. ADDRESS 28 West Potomac St. Wmspt. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 13-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md.			
24. FUNERAL DIRECTOR Mr. Albert L. Leaf Williamsport Md.				25a. REC'D BY REGISTRAR DATE DEC 13 1967		25b. REGISTRAR'S SIGNATURE Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17708

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17711

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>12 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Smithsburg</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Warren</u> Middle <u>K.</u> Last <u>Bush</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>12</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/21/1880</u>		9. AGE (In years lost birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Twp., Franklin Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harrison Bush</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Mellinger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-03-5085A</u>		17. INFORMANT <u>Mrs. Laura M. Bush, Smithsburg Md., #3</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-6</u> , 196 <u>7</u> , to <u>12-12</u> , 196 <u>7</u> , that (I) (we) last saw the deceased alive on <u>12-12</u> , 196 <u>7</u> , and that death occurred at <u>11:00</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. Hess</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>				22d. ADDRESS <u>Smithsburg Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harbaugh's</u>		23d. LOCATION (City or Town) (County) (State) <u>Smithsburg #3 Franklin Pa.</u>	
24. FUNERAL DIRECTOR <u>Walter Y. Grove</u>				ADDRESS <u>Waynesboro Pa.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 18 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1514
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Catherine Jones Campher			2a. DATE OF DEATH Month Day Year Dec 30 1967			2b. HOUR 5 P. M.					
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH Nov 15 1895		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Hampton Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
10. CITY OR TOWN OF DEATH Hagerstown Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 650 Penna. Ave. 211			
14. FATHER'S NAME First Middle Last Albert (NMN) Jones			15. MOTHER'S MAIDEN NAME First Middle Last Josephine Lyles								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT Address Walter Campher 650 Penna. Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Multiple Myocardial Infarctions DUE TO, OR AS A CONSEQUENCE OF (b) Thrombotic thrombocytopenic Purpura 10 days DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Dissecting Aortic Aneurysm											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Dec. 22, 1967, to Dec. 30, 1967, that (I) (we) last saw the deceased alive on Dec. 30, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Lloyd A. Hoffman DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED Jan 3-68	
22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22e. ADDRESS 214 N. Potomac St. Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Jan 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Washington Md.					
24. FUNERAL DIRECTOR John R. Wateen Jr. Hagerstown Md.						25a. REC'D BY REGISTRAR DATE JAN 8 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chewsville Rt. # 5	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS ---	
3. NAME OF DECEASED (Type or print) First Chester Middle Wishard Last Clark		4. DATE OF DEATH Month December Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1908
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months --- Days ---	IF UNDER 24 HRS. Hours --- Min. ---
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Goodwill Ind.	11. BIRTHPLACE (County & State, or foreign country) Chewsville Wash. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Adam	
14. MOTHER'S MAIDEN NAME Ella Florence Rowe		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 315-20-8948		17. INFORMANT Address Mrs. Bertha M. Clark Chewsville, Md Rt. 5	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH 20 yrs. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. ---	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-31 , 19 56 , to 12-21 , 19 67 , that (I) (we) last saw the deceased alive on 12-21 19 67 , and that death occurred at 11:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles F. Hess		22b. DATE SIGNED 12-23-67	
22c. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.		22d. ADDRESS Smithsburg, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 24, 1967	23c. NAME OF CEMETERY OR CREMATORY Chewsville E.U.B. Cem. Chewsville Wash. Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR A.K. Coffman Funeral Home Inc. 40 E. Antietam St. Hagerstown, Md.		25a. REC'D BY REGISTRAR DEC 27 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

100

MEMORANDUM FOR THE DIRECTOR

DATE: 10/10/68

TO: DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [REDACTED]

RE: [REDACTED]

1. [REDACTED]

2. [REDACTED]

3. [REDACTED]

4. [REDACTED]

5. [REDACTED]

6. [REDACTED]

7. [REDACTED]

8. [REDACTED]

[REDACTED]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md. d. STREET ADDRESS 815 Columbia Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Michael P. Cunningham				4. DATE OF DEATH Month Dec Day 4 Year 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/23/03		9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mail Carrier Post Office				10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (County & State, or foreign country) Mt. Savage Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Cunningham				14. MOTHER'S MAIDEN NAME Sarah Lynch					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-07-0031		17. INFORMANT Address Mrs. Michael P. Cunningham Cumberland Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA COLON DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____			
21. I certify that (I) (this hospital) attended the deceased from 10-12-1967, to 12-4-1967, that (I) (we) last saw the deceased alive on 12-4-1967, and that death occurred at 6:45 PM, from the causes and on the date stated above.									
22a. SIGNATURE Domingo A. Garcia				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12-5-67			
22c. PHYSICIAN'S NAME (Type) DOMINGO A. GARCIA				22d. ADDRESS WESTERN MARYLAND STATE HOSPITAL					
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF 12/9/67		23c. NAME OF CEMETERY OR CREMATORY Sunset Manor Pk.		23d. LOCATION (City, town or county) (State) Cumberland Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.				25a. REC'D BY REGISTRAR DEC 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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Michael P Cunningham
Dec 4 '67

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15-2-23

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17712

17715

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 9 MOS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 548 W. CHURCH ST.		d. STREET ADDRESS RT.#1	
3. NAME OF DECEASED (Type or print) First PAULINE Middle ROSELLA Last DANNER		4. DATE OF DEATH Month DECEMBER Day 1 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/1909
9. AGE (In years and birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR HOME	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN FISHER		14. MOTHER'S MAIDEN NAME IVY WALLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-12-1212	
17. INFORMANT MR. EMORY M. DANNER		18. ADDRESS BOONSBORO RT#1 MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 170X IMMEDIATE CAUSE (a) Carcinoma of left breast with metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. , 19 67 , to Dec. 1 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 1 , 19 67 , and that death occurred at 9:00 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Omar D. Sprecher, Jr.		22b. DATE SIGNED 12/2/67	
22c. PHYSICIAN'S NAME (Type) Omar D. SPRECHER, Jr.		22d. ADDRESS 1229 Ravenwood Heights Hagerstown, Maryland	
23a. BURIAL CREMATION, BURIAL	23b. DATE THEREOF 12/4/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W. J. Normant, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 6 1967	
25b. REGISTRAR'S SIGNATURE O. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Examination of left breast with no tumor

Feb. 1907
D.A.

12/2/07
1224 Ravenswood Heights
Hagerstown, Maryland

Dec 1 1907
Omar D. Sprecher, Jr.
Omar D. Sprecher, Jr.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17713

17716

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg</u> RD 1 <u>10.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>Garfield</u>	
3. NAME OF DECEASED (Type or print) <u>HARRY EDWARD DRAPER</u>		4. DATE OF DEATH <u>Dec. 31</u> 19 <u>67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-1886</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hanson C. Draper</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Weddle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-0687A</u>	
17. INFORMANT <u>Mrs. Edgar Draper</u>		Address <u>RD1 Smithsburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-2-58</u> , 19 <u> </u> , to <u>12-31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12-30</u> 19 <u>67</u> , and that death occurred at <u>7:30AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles F. Hess</u>		22b. DATE SIGNED <u>1-1-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u>		22d. ADDRESS <u>Smithsburg, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-3-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Methodist Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Garfield Fred. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Raymond E. Cragger</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Raymond E. Cragger</u>		DATE <u>JAN 5 1968</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

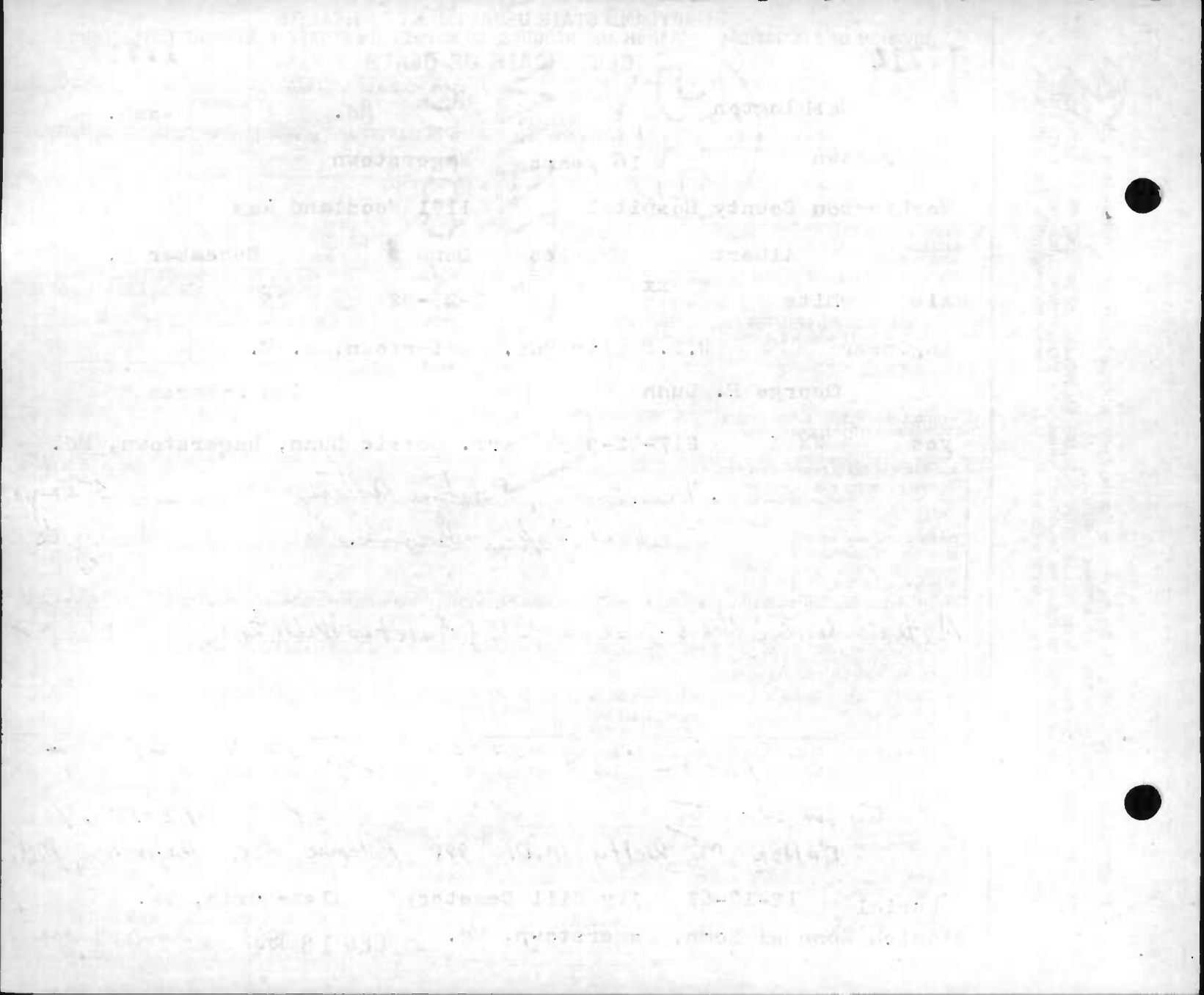
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17714

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17717

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 16 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1101 Woodland Way e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Albert Middle Charles Last Dunn				4. DATE OF DEATH Month December Day 9 Year 1967			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-23-92	
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months 7 Days 1		IF UNDER 24 HRS. Hours 21 Min. 1			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY U.S. Public Rds.		11. BIRTHPLACE (County & State, or foreign country) Watertown, N. Y.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME George R. Dunn				14. MOTHER'S MAIDEN NAME Mina DeMarse			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WW I				16. SOCIAL SECURITY NO. 217-42-9454		17. INFORMANT Address Mrs. Bessie Dunn, Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, Pontine Artery 332X DUE TO Cerebral Arteriosclerosis (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 3 days 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease 3C; Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-20 , 19 53 to 12-9 , 19 67 , that (I) was last saw the deceased alive on 12-9 , 19 67 , and that death occurred at 8:07 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Dalton M. Welty				22b. DATE SIGNED 12-11-67			
22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.				22d. ADDRESS 998 Potomac Ave. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12-12-67		23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		23d. LOCATION (City, town or county) (State) Alexandria, Va.	
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR DEC 13 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN TB 1M. 7 D. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rohrersville d. STREET ADDRESS 21-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Faye Catherine Easton		4. DATE OF DEATH December 15, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1916
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 10 Days 26 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper- Clerk		10b. KIND OF BUSINESS OR INDUSTRY General Store	
11. BIRTHPLACE (County & State, or foreign country) Rohrersville, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Chester M. Mullendore		14. MOTHER'S MAIDEN NAME Lestia Potter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 220-09-2814	
17. INFORMANT Mr. Arthur C. Easton, Rohrersville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CANCER TO BOTH LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PLEURAL EFFUSION DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from April, 1966 , to Dec 15, 1966 , that (1) (we) last saw the deceased alive on 12/15/67 , and that death occurred at 8:30 AM , from causes and on the date stated above.			
22a. SIGNATURE R. Amarillo		22b. DATE SIGNED 12/15/67	
22c. PHYSICIAN'S NAME (Type) R. Amarillo		22d. ADDRESS Sharpsburg, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12- 17- 67	23c. NAME OF CEMETERY OR CREMATORY Rohrersville Cemetery	23d. LOCATION (City or Town) (County) (State) Rohrersville, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR DEC 20 1967	
25b. REGISTRAR'S SIGNATURE John H. Bast, Jr.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Edna Dyer Eggers</i>					2a. DATE OF DEATH Month <i>Dec</i> Day <i>19</i> Year <i>1967</i>			2b. HOUR <i>7:38 PM</i>		
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>Sept 25, 1888</i>			6. AGE (In years lost birthday) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS <i>7</i> DAYS <i>19</i> HOURS <i>19</i> MIN.	
7a. BIRTHPLACE (State or foreign country) <i>YORK</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.				
10. CITY OR TOWN OF DEATH <i>Williamsport</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Home Road Church Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Business</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Bakereater</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Pa</i>			13b. COUNTY <i>York</i>		13c. CITY OR TOWN <i>York</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>740 W. Locust St</i>	
14. FATHER'S NAME First <i>William James</i> Middle <i>Dyer</i> Last <i>Dyer</i>					15. MOTHER'S MAIDEN NAME First <i>Isabelle</i> Middle <i>A</i> Last <i>Spangler</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>199-18-2843</i>		17. INFORMANT Address <i>Mark G. Wagner Williamsport, Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>4201</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive C.V. Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i> <i>10 years</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Gouty arthritis</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>12</i> Day <i>19</i> Year <i>1967</i> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <i>12-14</i>		City or Town <i>York</i>		County <i>York</i> State <i>Pa</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>12-1-67</i> , 19 <i>67</i> , to <i>12-19-67</i> , 19 <i>67</i> , that (I) (we) lost the deceased alive on <i>12-14-67</i> , 19 <i>67</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert P. Conrad MD</i>					DEGREE <i>MD</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12-19-67</i>	
22d. PHYSICIAN'S NAME (Type) <i>Robert P. Conrad</i>					22e. ADDRESS <i>Hagerstown, Md</i>					
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>12/22/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Cem.</i>		23d. LOCATION (City or Town) <i>York</i>		(County) <i>York</i> (State) <i>Pa</i>		
24. FUNERAL DIRECTOR <i>Hagerstown, Md</i> <i>Andrew K. Coffman Funeral Home Inc</i>					25a. REC'D BY REGISTRAR DATE <i>DEC 22 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

17717

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17720

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>4 yrs 8 mos.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chambersburg</u>		753	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Sanitarium</u>		d. STREET ADDRESS <u>Route #6</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SUSAN</u> Middle <u>MAY</u> Last <u>Faubel</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27, 1872</u>
9. AGE (In years lost birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ladies Clothing</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry W. Faubel</u>		14. MOTHER'S MAIDEN NAME <u>Margaret E. Kuhl</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>204-40-3953</u>	
17. INFORMANT <u>Wife</u> Address <u>RE #6</u>		<u>Miss Eleanor Walk Chambersburg, PA.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 acute myocardial infarction</u> DUE TO (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>45</u> , to <u>December</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>28 November 67</u> , and that death occurred at <u>1 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edson B. Mobdy</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Edson B. Mobdy M.D.</u>		22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Greencastle Franklin Pa.</u>
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 26 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1971

OFFICE OF CHIEF

1971

1971-01-01

John A. Hunt

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 26 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HOLLIS Middle STEAVER Last FOUT		4. DATE OF DEATH Month DECEMBER Day 13 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 9, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. PRODUCTION WORKER		10b. KIND OF BUSINESS OR INDUSTRY FAIRCHILD AIRCRAFT	9. AGE (In years last birthday) yrs. 68
11. BIRTHPLACE (County & State, or foreign country) ROANOKE, VIRGINIA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. FOOT		14. MOTHER'S MAIDEN NAME ROSA BOWYER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-10-5680	
17. INFORMANT MRS. SHIRLEY MILLER,		Address # 6 HAGERSTOWN, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5811 acute liver failure DUE TO (b) alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Anchosis of liver, Hypertensive cardiac dis			INTERVAL BETWEEN ONSET AND DEATH 2 wks. year.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) Richard T. Binford attended the deceased from 4 Jan 1960 to 13 Dec 1967 that (I) never last saw the deceased alive on 13 Dec 1967 , and that death occurred at 7:10 M, from causes and on the date stated above.			
22a. SIGNATURE Richard T. Binford		22b. DATE SIGNED 12/15/67	
22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M.D.		22d. ADDRESS 1135 POTOMAC AVE. HAGERSTOWN, MARYLAND.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/16/67	23c. NAME OF CEMETERY OR CREMATORY MOUNT HOPE CEMETERY,	23d. LOCATION (City or Town) (County) (State) WOODSBORO, FREDERICK CO. MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR DEC 18 1967	25b. REGISTRAR'S SIGNATURE Charles J. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17722

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First Margaret Middle Mae Last Fox		4. DATE OF DEATH Month Dec. Day 15 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17-1910
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY _____	9. AGE (In years last birthday) 57 yrs.
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Pearl		14. MOTHER'S MAIDEN NAME Daisy M. Stockman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-4355	
17. INFORMANT John S. Fox-501 S. Market Street-Frederick-		Address Md. 21701	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 1930 DUE TO (b) Tentorial brain herniation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) Malignant astrocytoma Left temporal lobe			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 7, 1967 , to Dec. 15, 1967 , that (I) (we) last saw the deceased alive on Dec. 15, 1967 , and that death occurred at 7 P. M, from causes and on the date stated above.			
22a. SIGNATURE A. F. Abdullah		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 12-16-67
22c. PHYSICIAN'S NAME (Type) A. F. Abdullah		22d. ADDRESS 132 N. Potomac, Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-18-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR M.R. Etchison & Son		ADDRESS Whitmore Frederick, Md. 21701	25a. REC'D BY REGISTRAR DATE DEC 19 1967
		25b. REGISTRAR'S SIGNATURE John S. Fox	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1877

STATE OF OHIO

1877

Frederick

Maryland

Washington

Frederick - Maryland

8 days

Washington

Washington County Hospital

Dec. 15 - 1877

Oct. 17-1910

Female White

U.S.A.

Frederick Co. Md.

Honorable

Deputy M. Stockman

Charles W. Perry

MD. 21701

John S. Fox-John S. Leonard Street-Frederick-

No

Frederick, Md. 21701

MD. Oliver Cemetery

12-18-1907

Burial

Frederick, Md. 21701

W. H. Johnson & Son

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY in 1b 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring R #1 21-1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital						d. STREET ADDRESS Near St. Pauls				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Matilda Last Frush						4. DATE OF DEATH Month December Day 26 Year 1967					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1897		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Wash. Co. Clear Spring Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.A.	
13. FATHER'S NAME George B. Sword						14. MOTHER'S MAIDEN NAME Nancy Suffecool					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. None		17. INFORMANT Address R#1 Norman V. Frush Clear Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from Jan , 19 67 to Dec 26 , 19 67 that (1) (we) last saw the deceased alive on 12-26 , 19 67 , and that death occurred at 12:30 M, from causes and on the date stated above.											
22a. SIGNATURE <i>[Signature]</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-28-67			
22c. PHYSICIAN'S NAME (Type) ME Byrkit						22d. ADDRESS Williamsport Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/28/67		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery				23d. LOCATION (City or Town) (County) (State) Clear Spring Wash Md.			
24. FUNERAL DIRECTOR 40 E. Antietam St. Hagerstown						25a. REC'D BY REGISTRAR JAN 2 1968		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
A.K. Coffman Funeral Home Inc. Md.											

11750

ST 1

10-10-54

MEMORANDUM

TO: THE CHIEF OF STAFF

FROM: THE CHIEF OF STAFF

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

4 1
17721
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17724

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 111 METHODIST AVENUE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK d. STREET ADDRESS 111 METHODIST AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JESSE BENJAMIN FUNK First Middle Last		4. DATE OF DEATH DECEMBER 13, 1967 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/14/1891 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY FARM SUPPLY	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JONATHAN FUNK		14. MOTHER'S MAIDEN NAME CHARIETY HERSHMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 232-03-2631	
17. INFORMANT ADAH W. FUNK		Address HANCOCK, MD. 111 METHODIST AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion (c) arterio sclerosis		INTERVAL BETWEEN ONSET AND DEATH instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 13, 1967 , to Dec 13, 1967 , that (I) (we) last saw the deceased alive on Dec 13, 1967 , and that death occurred at 8A M, from causes and on the date stated above.			
22a. SIGNATURE L M SHAFER M.D.		22b. DATE SIGNED 12/16/67	
22c. PHYSICIAN'S NAME (Type) L M SHAFER		22d. ADDRESS HANCOCK, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/17/67	
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET METHODIST		23d. LOCATION (City or Town) (County) (State) RURAL BERKELEY MORGAN	
24. FUNERAL DIRECTOR Howard J. Moore Hancock Md		25a. REC'D BY REGISTRAR DEC 20 1967	
		25b. REGISTRAR'S SIGNATURE John H. Morgan	

17751

UNITED STATES OF AMERICA

17751

WASHINGTON

MARYLAND

WASHINGTON

HANDSON

LIFE

HANDSON

111 METHODIST AVENUE

111 METHODIST AVENUE

LEWIS

REHABILIATION

FUNK

DECEMBER 19

MALE WHITE

11/11/1981

CLERK

FARM SUPPLY

WEST VIRGINIA

U.S.A.

JOHANNAN FUNK

CHARITY MEMBERSHIP

232-00-0001 AGAR & FUNK 111 METHODIST AVE.

HANDSON, MD.

[Faint, illegible handwritten notes and signatures covering the bottom half of the page.]

FINAL

UNITED STATES OF AMERICA

RECEIVED BY JORDAN 11/11/81

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17722

17725

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNA. b. COUNTY FRANKLIN			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GREENCASTLE 753			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. CO. HOSPITAL				d. STREET ADDRESS 119 N. Allison St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUY Middle G. Last GLASER				4. DATE OF DEATH Month DEC. Day 5 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1920	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECURITY GUARD - MANUF. CO.		10b. KIND OF BUSINESS OR INDUSTRY Franklin Co., Penna.		11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME KARL GLASER				14. MOTHER'S MAIDEN NAME RHODA STOFFER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or if known) NO		16. SOCIAL SECURITY NO. 203-10-8100		17. INFORMANT Mrs. Mildred Glaser - Greencastle Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertensive Vascular Disease DUE TO (c) 5 yrs.						INTERVAL BETWEEN ONSET AND DEATH 16 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/4 , 19 67 , to 12/5 , 19 67 that (I) was last saw the deceased alive on 12/5 , 19 67 and that death occurred at 1:40 P.M. from causes and on the date stated above.							
22a. SIGNATURE W.C. BREWER				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/6/67	
22c. PHYSICIAN'S NAME (Type) W.C. BREWER				22d. ADDRESS GREENCASTLE, PENNA.			
23a. BURIAL, CREMATION, REMOVAL (Specify) B		23b. DATE THEREOF 12/8/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Greencastle Pa.	
24. FUNERAL DIRECTOR A.E. Mennich - GREENCASTLE, PA.				25a. REC'D BY REGISTRAR DEC 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
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1175

STATE OF TEXAS

1937

IN SENATE
JANUARY 15, 1937
REPORT
OF THE
COMMISSIONER OF AGRICULTURE
AND MECHANICAL INDUSTRIES
FOR THE YEAR 1936
BY
J. C. GILBERT
COMMISSIONER
OF AGRICULTURE
AND MECHANICAL INDUSTRIES
OF THE STATE OF TEXAS
DALLAS, TEXAS
1937

THE STATE OF TEXAS
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C. 20250
1937

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17723

CERTIFICATE OF DEATH

17726

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 518 E. Wilson Blvd.	
3. NAME OF DECEASED (Type or print) Franklin Oatis Gochenour		4. DATE OF DEATH Month Dec. Day 24 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/15/20
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) attendant		10b. KIND OF BUSINESS OR INDUSTRY gas station	
11. BIRTHPLACE (County & State, or foreign country) Fairfield, Illinois		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Gochenour		14. MOTHER'S MAIDEN NAME Violet Holmes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes WWII		16. SOCIAL SECURITY NO. 330-01-7015	
17. INFORMANT Leah Gochenour		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest - Central Artery DUE TO (b) Atherosclerosis - Coronary Thrombosis DUE TO (c) Diabetes Mellitus			INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1965 , to 24 Dec 1967 , that (I) (we) last saw the deceased alive on 24 Dec 1967 , and that death occurred at 2400 M, from causes and on the date stated above.			
22a. SIGNATURE J. Wilson		22b. DATE SIGNED 12/26/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/27/67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 29 1967	
		25b. REGISTRAR'S SIGNATURE O. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13323

13323

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON

WASHINGTON COUNTY, MARYLAND

WASHINGTON COUNTY, MARYLAND

WASHINGTON COUNTY, MARYLAND

WASHINGTON COUNTY, MARYLAND

WASHINGTON COUNTY, MARYLAND

WASHINGTON COUNTY, MARYLAND

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WASHINGTON COUNTY, MARYLAND

WASHINGTON COUNTY, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

<div>17724</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>17727</div>											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY Wash.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Williamsport Sanitarium						d. STREET ADDRESS 118m Broadway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leslie Middle Basore Last Halbach				4. DATE OF DEATH Month December Day 7 Year 19 67							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-11-03		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) parts control				10b. KIND OF BUSINESS OR INDUSTRY aircraft mfg.		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John E. Halbach						14. MOTHER'S MAIDEN NAME Naomi Ridenour					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214-10-4645		17. INFORMANT Address Mrs. James Fockler, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and severe emphysema? 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH sev. weeks											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic alcoholism and malnutrition										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan. , 19 55 , to Dec. , 19 67 that (I) (we) last saw the deceased alive on December 5 1967 , and that death occurred at 2:30 PM , from causes and on the date stated above.											
22a. SIGNATURE <i>Howard N. Weeks</i> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/8/67			
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M. D.						22d. ADDRESS 580 Northern Ave., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-67		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery				23d. LOCATION (City or Town) (County) (State) ClearSpring, Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.						25a. REC'D BY REGISTRAR DEC 11 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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RECORD OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 608 NORTH PROSPECT STREET	
3. NAME OF DECEASED (Type or print) First ROBERT Middle MARSHALL Last HANNAN		4. DATE OF DEATH Month DECEMBER Day 9, Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 15, 1894
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY SHOE & LEGGING CO.	
11. BIRTHPLACE (County & State, or foreign country) CARLISLE, PENNSYLVANIA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES S. HANNAN		14. MOTHER'S MAIDEN NAME JULIA SCHRODENBAUGH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO *****		16. SOCIAL SECURITY NO. 214-09-0151	
17. INFORMANT MR. RICHARD M. HANNAN, HAGERSTOWN, MARYLAND.		18. ADDRESS 1421 VIRGINIA AVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Heart Failure 4221 DUE TO (b) Cardiosclerosis DUE TO (c) General Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 mos. Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-18 , 19 67 , to 11-9-67 , 19 67 , that (I) (we) last saw the deceased alive on 11-9-67 , 19 67 , and that death occurred at 10:30 M, from causes and on the date stated above.			
22a. SIGNATURE Robert F. Keagle ROBERT F. KEAGLE, M.D.		22b. DATE SIGNED 12/11/67	
22c. PHYSICIAN'S NAME (Type) ROBERT F. KEAGLE, M.D.		22d. ADDRESS 580 NORTHERN AVE. HAGERSTOWN, MARYLAND.	
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/12/67	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR DEC 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1175

WASHINGTON COUNTY

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17726

17731

1. PLACE OF DEATH a. COUNTY Wash. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown c. LENGTH OF STAY IN b 2 Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Avalon Manor		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1106 Orchard Hill Pwky. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Grace Last Hayes		4. DATE OF DEATH Month December Day 6, Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Emory H. Carty		14. MOTHER'S MAIDEN NAME Alice Dayhoff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-52-2113	
17. INFORMANT Leo F. Hayes		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C. - V. Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ext. Hemiplegia due to Cerebral Hem. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Transf. 7 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr 2 , 19 67 to June 6 , 19 67 , that (I) (we) last saw the deceased alive on June 5 , 19 67 , and that death occurred at 6:00 AM , from causes and on the date stated above.			
22a. SIGNATURE Sidney Novenstein		22b. DATE SIGNED 12-6-67	
22c. PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN		22d. ADDRESS FUMKSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-8-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		25a. REC'D BY REGISTRAR DEC 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13326

PRINCIPAL OF GRAIN

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1100 Orchard Hill Way
Haverhill
Mass

Alice Grace Hayes

27-10-32

Mass

John J. Hayes

27-10-32

Handwritten:
Haverhill
Mass

Handwritten:
Grand Treasurer
Society of Women
12-2-32

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 128 SOUTH LOCUST STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE MARIA HEIL			4. DATE OF DEATH Month Day Year DECEMBER 13, 1967				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 3, 1889	9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STITCHER		10b. KIND OF BUSINESS OR INDUSTRY SHOE MFG. CO.		11. BIRTHPLACE (County & State, or foreign country) HAGERSTOWN, MARYLAND.			
13. FATHER'S NAME ELLIS M. STOFFER			14. MOTHER'S MAIDEN NAME FLORENCE SPIELMAN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year at dates of service) ****		16. SOCIAL SECURITY NO. 214-09-5516A		17. INFORMANT 423 S. POTOMAC ST. MRS. LORRAINE GEARY, HAGERSTOWN, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH 30 min		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Radiation pneumonia R. lung following therapy for carcinoma							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) of breast					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that (I) (NAME) attended the deceased from <u>2-23, 1939</u> to <u>12-13, 1967</u>, that (I) (NAME) saw the deceased alive on <u>12/13 1967</u>, and that death occurred at <u>8:10 AM</u>, from causes and on the date stated above.							
22a. SIGNATURE John H. Hornbaker, M.D.			22b. DATE SIGNED 12/15/67		22c. PHYSICIAN'S NAME (Type) JOHN H. HORNBAKER, M.D.		
22d. ADDRESS 154 W. WASHINGTON ST. HAGERSTOWN, MD.			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/15/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY			
23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.		24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.					
25a. REC'D BY REGISTRAR DEC 18 1967			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 18 Film 396 12-27-67 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17728

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17733

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN TB <u>DDA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON COUNTY HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BIG SPRING</u> d. STREET ADDRESS <u>RED-1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>DOROTHY ANN HENSLEY</u>		4. DATE OF DEATH <u>DEC 5TH 1967</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 9, 1967</u>		9. AGE (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND WASH.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS DAVID HENSLEY</u>				14. MOTHER'S MAIDEN NAME <u>DOROTHY ANN MULLINIX</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>THOMAS DAVID HENSLEY</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SDII</u> <u>492 X</u> DUE TO <u>Acute interstitial pneumonia, Bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTERSTITIAL</u> (c) <u>INTERSTITIAL</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute pyelonephritis, Bilateral</u>																		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>																					
22. ACTUAL SIGNATURE <u>Edward W. Ditto, III</u> M.D. EXAMINER'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>				22. DATE SIGNED <u>217 W. Wash. St. 67 Hagerstown, Md.</u>																	
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>DEC. 7, 67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR LAWN PARK</u>				23d. LOCATION (City or Town) (County) (State) <u>HAGERSTOWN WASH. MD.</u>									
24. FUNERAL DIRECTOR <u>DONALD E. THOMPSON</u>				25a. REC'D BY REGISTRAR <u>DEC 8 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>													

STANDARD INFORMATION SYSTEM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17729

17734

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 5 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg Rfd. 2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jackson Convalescent Home				d. STREET ADDRESS White Hall Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Carlotta Pearl Hoover				4. DATE OF DEATH Month Day Year December 25, 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 11, 1900	
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 2 14		11. BIRTHPLACE (County & State, or foreign country) White Hall Wash. Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY +++++		11. BIRTHPLACE (County & State, or foreign country) White Hall Wash. Co., Md.	
13. FATHER'S NAME Elvin I. Hoover				14. MOTHER'S MAIDEN NAME Katie Eckstine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.				16. SOCIAL SECURITY NO. 213-48-2738		17. INFORMANT Address Md. Mrs. Katie E. Hoover, Rfd. 2, Smithsburg,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 250X DUE TO (b) Atherosclerotic Cardiovascular Disease DUE TO (c) Thyroid Gaster Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 years 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-9, 1956 , to 12-25, 1967 , that (I) (we) last saw the deceased alive on 12-11, 1967 , and that death occurred at 5:30 A.M. , from causes and on the date stated above.							
22a. SIGNATURE Charles F. Hess				22b. DATE SIGNED 12-25-67		22c. PHYSICIAN'S NAME (Type) Charles F. Hess, M. D.	
22d. ADDRESS Smithsburg, Maryland				22e. ADDRESS Smithsburg, Maryland			
23a. BURIAL, CREMATION, or REMOVAL (Specify) Entombment		23b. DATE THEREOF 12-27-67		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Mausoleum		23d. LOCATION (City or Town) (County) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR DEC 28 1967		25b. REGISTRAR'S SIGNATURE O. Charles Judge	

17739

17739

STATE OF MARYLAND

County of Prince George's

Shirley, Virginia

Shirley, Virginia

Shirley, Virginia

Shirley, Virginia

Shirley, Virginia

Shirley, Virginia

Shirley, Virginia

Shirley, Virginia

Shirley, Virginia

Shirley, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport RFD #1		c. LENGTH OF STAY IN 1b 27 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Williamsport, Md. RFD #1		d. STREET ADDRESS Williamsport, Md. RFD #1	
3. NAME OF DECEASED (Type or print) First George Middle Frederick Last Hosfeld		4. DATE OF DEATH Month Dec. Day 31 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1886
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 10 Days 20	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pattern Maker		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	11. BIRTHPLACE (County & State, or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Casper Frederick Hosfeld	
14. MOTHER'S MAIDEN NAME Anna May Zearn		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-09-8894		17. INFORMANT Mrs. Florence M. Hosfeld Address Williamsport, Md. RFD #1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Cerebral Arteriosclerosis DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 15, 1967 , to Dec 31, 1967 , that (I) (we) last saw the deceased alive on Dec 26, 1967 , and that death occurred at 2 A.M. from causes and on the date stated above.			
22a. SIGNATURE A. E. W. Dittor		22b. DATE SIGNED Jan 3, 1968	22c. PHYSICIAN'S NAME (Type) A. E. W. Dittor
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 3, 1968	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery
23d. LOCATION (City or Town) (County) (State) Hagerstown, Washington, Md.		24. FUNERAL DIRECTOR Albert L. Leaf ADDRESS Williamsport, Md.	
25a. REC'D BY REGISTRAR JAN 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

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3. Results

MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) HERBERT HUBERT HUMPHREY			2a. DATE OF DEATH Month Dec Day 31 Year 1967			2b. HOUR 11 A M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept 13 1884		6. AGE (In years lost birthday) 83 YRS.	
7a. BIRTHPLACE (State or foreign country) Paw Paw W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Install Furnaces		12b. KIND OF BUSINESS OR INDUSTRY --	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington		13c. CITY OR TOWN Clear Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER R # 1		14. FATHER'S NAME First Middle Last William T Humphrey		15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth R. Bohrer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 214-09-8877		17. INFORMANT Frank W. Bell		Address Clear Spring Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24h. yr.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12/31 , 19 67 , to 12/31 , 19 67 , that (I) (we) last saw the deceased alive on 12/31 , 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE D. J. Boyer		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-68	
22d. PHYSICIAN'S NAME (Type) D. J. Boyer, M.D.		22e. ADDRESS 136 N. Potomac Street, Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/3/68		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman		Funeral Home Inc		25a. FILED BY REGISTRAR JAN 5 1968		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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133

THE UNIVERSITY OF CHICAGO

DEPT. OF CHEMISTRY

CHICAGO, ILL.

TO THE DIRECTOR OF THE NATIONAL BUREAU OF STANDARDS

WASHINGTON, D. C.

FROM THE DEPARTMENT OF CHEMISTRY

UNIVERSITY OF CHICAGO

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
17732									
17737									
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro Rfd. 2 d. STREET ADDRESS Mapleville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Howard Middle William Last Irving					4. DATE OF DEATH Month December Day 12 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 26, 1901		9. AGE (In years last birthday) 66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Fish Hatchery		11. BIRTHPLACE (County & State, or foreign country) Frederich Co., Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Elmer Irving					14. MOTHER'S MAIDEN NAME Leorh Haupt				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.			16. SOCIAL SECURITY NO. 213-18-9037		17. INFORMANT Mrs. Esther V. Irving, Rfd. 2, Boonsboro, Md. Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left heart failure 331X DUE TO (b) Cerebral Pulsion Eage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Conjunctive heart failure								INTERVAL BETWEEN ONSET AND DEATH 7 day 2 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-24 , 19 67 , to 12-12 , 19 67 , that (I) (we) last saw the deceased alive on 12-12 , 19 67 , and that death occurred at 12:30 A.M., from causes and on the date stated above.									
22a. SIGNATURE Joseph Secondari					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12. 12. 67		
22c. PHYSICIAN'S NAME (Type) JOSEPH SECON DARI					22d. ADDRESS Boonsboro Md 21713				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12- 14- 67		23c. NAME OF CEMETERY OR CREMATORY Mt. Lena Cemetery			23d. LOCATION (City or Town) (County) (State) Mt. Lena, Wash. Co., Md.		
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md ADDRESS					25a. REC'D BY REGISTRAR DEC 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

1173

STATE OF MARYLAND

1173

Washington

Maryland

Local Board of Health

to Day

Department

Maryland

Department of Health

State of Maryland

Department

Health

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April 10, 1901

White

Male

U. S. A.

Department of Health

Local Board

Local

Local Board

Local Board

215-18-2017

No.

Mr. John H. Smith, M.D., Wash. D.C.

Mr. John H. Smith, M.D., Wash. D.C.

15-11-21

1173

John H. Smith, M.D., Wash. D.C., December 11, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
17733									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY in yrs. 60 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					d. STREET ADDRESS 1031 VIEW ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRA Middle WILLIAM Last KAUFFMAN					4. DATE OF DEATH Month DECEMBER Day 5 Year 1967				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/23/1899		9. AGE (In years last birthday) yrs. 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY FURNITURE MFG. CO.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM KAUFFMAN					14. MOTHER'S MAIDEN NAME REBECCA SHIVES				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			16. SOCIAL SECURITY NO. 214-09-6720		17. INFORMANT Address HAGERSTOWN MD. MR. CARL J. KAUFFMAN				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Emphysema DUE TO (c) Congestive Heart Failure, Chronic								INTERVAL BETWEEN ONSET AND DEATH 2 days Years 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 30 Nov. 1967 , to 5 Dec. 1967 , that (I) (we) last saw the deceased alive on 5 Dec 1967 and that death occurred at 5:10 PM from causes and on the date stated above.									
22a. SIGNATURE J. D. Wilson					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. DR. J. D. WILSON			22b. DATE SIGNED 12/6/67	
22c. PHYSICIAN'S NAME (Type) DR. J. D. WILSON					22d. ADDRESS NORTHERN AVE. HAGERSTOWN, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/8/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.			23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.		
24. FUNERAL DIRECTOR W. Norment Hagerstown, Md.					25a. REC'D BY REGISTRAR DATE DEC 11 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17734

17739

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN			c. LENGTH OF STAY IN lb 80 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			J-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) AVALON MANOR CONVALESCENT HOME				d. STREET ADDRESS 814 DEWEY AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH EARL KNOTT, SR.				4. DATE OF DEATH Month Day Year DECEMBER 22, 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH NOVEMBER 5, 1893		9. AGE (In years last birthday) yrs. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALES ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY APPLIANCE SALES		11. BIRTHPLACE (County & State, or foreign country) GLYMOUNT, MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM J. KNOTT				14. MOTHER'S MAIDEN NAME SUSAN REBECCA PRICE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ****		16. SOCIAL SECURITY NO. 214-09-9661		17. INFORMANT MRS. MYRTLE A. KNOTT, 814 DEWEY AVENUE, HAGERSTOWN, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis, right cerebral artery 332X DUE TO Arteriosclerosis, cerebral with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) contraction right ant. cerebral DUE TO artery (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2 months 2 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from OCT 13, 1967 , to DEC 22, 1967 , that (I) was lost the deceased alive on 12/18 1967 , and that death occurred at 6:45 P M, from causes and on the date stated above.							
22a. SIGNATURE <i>George Jennings</i>				22b. DATE SIGNED 12/26/67.		22c. PHYSICIAN'S NAME (Type) GEORGE JENNINGS, M.D.	
22d. ADDRESS 318 N. POTOMAC ST. HAGERSTOWN, MARYLAND.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/27/67		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR JAN 2 1968		25b. REGISTRAR'S SIGNATURE <i>Judge</i>	

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Abstract

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b D.O.A d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharpsburg d. STREET ADDRESS 215 E. Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leo First Rodney Middle Leatherman Last R		4. DATE OF DEATH Month Dec. Day 13 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2 1903
9. AGE (in years last birthday) 63 64 yrs.		IF UNDER 1 YEAR Months 11 Days 10	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholster		10b. KIND OF BUSINESS OR INDUSTRY Hess Auto Body	11. BIRTHPLACE (County & State, or foreign country) Sharpsburg Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Alvey Leatherman	
14. MOTHER'S MAIDEN NAME Goldie Gray		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 214 09 6285		17. INFORMANT Mrs. Marjorie Leatherman	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH half hour years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 4-9- , 19 57 , to 12-13 , 19 67 , that (I) (we) last saw the deceased alive on 12-13- 19 67 , and that death occurred at 4P M, from the causes and on the date stated above.	
22a. SIGNATURE Joseph Secomari		22b. DATE SIGNED 12-14-67	
22c. PHYSICIAN'S NAME (Type) JOSEPH SECOMARI		22d. ADDRESS BOONSBORO Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 16-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town or county) (State) Sharpsburg Wash. Md.	
24. FUNERAL DIRECTOR Albert L. Leaf		25a. REC'D BY REGISTRAR DEC 18 1967	
25b. REGISTRAR'S SIGNATURE John L. Judge			

Washington

Washington

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U.S.A.

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Washington County Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17736

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17743

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Downsville				c. LENGTH OF STAY IN 1b Minutes			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Church Of Brethren				d. STREET ADDRESS Rural Williamsport RFD #1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Brown Middle Cushwa Last Long				4. DATE OF DEATH Month Dec. Day 10 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10 1889		9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR Months 2 Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Mc Clellan Long				14. MOTHER'S MAIDEN NAME Agnes Line			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220 34 2305		17. INFORMANT Mr. Lawrence Long Address Downsville Williamsport Md. RFD 1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion from arteriosclerosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Instant Indefinite							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 5 , 19 65 , to Dec. 10 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 1 , 19 67 , and that death occurred at 9:45A. M, from causes and on the date stated above.							
22a. SIGNATURE <i>B. B. Kneisley</i>				MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/11/67	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley				22d. ADDRESS 148 W. Washington St. Eagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 13-67		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION (City or Town) (County) (State) Tilghmanton Md.	
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.				25a. REC'D BY REGISTRAR DATE DEC 13 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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1778

Washington

Washington

Hotel Chippewa

Hotel Chippewa

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Oct. 10 1899

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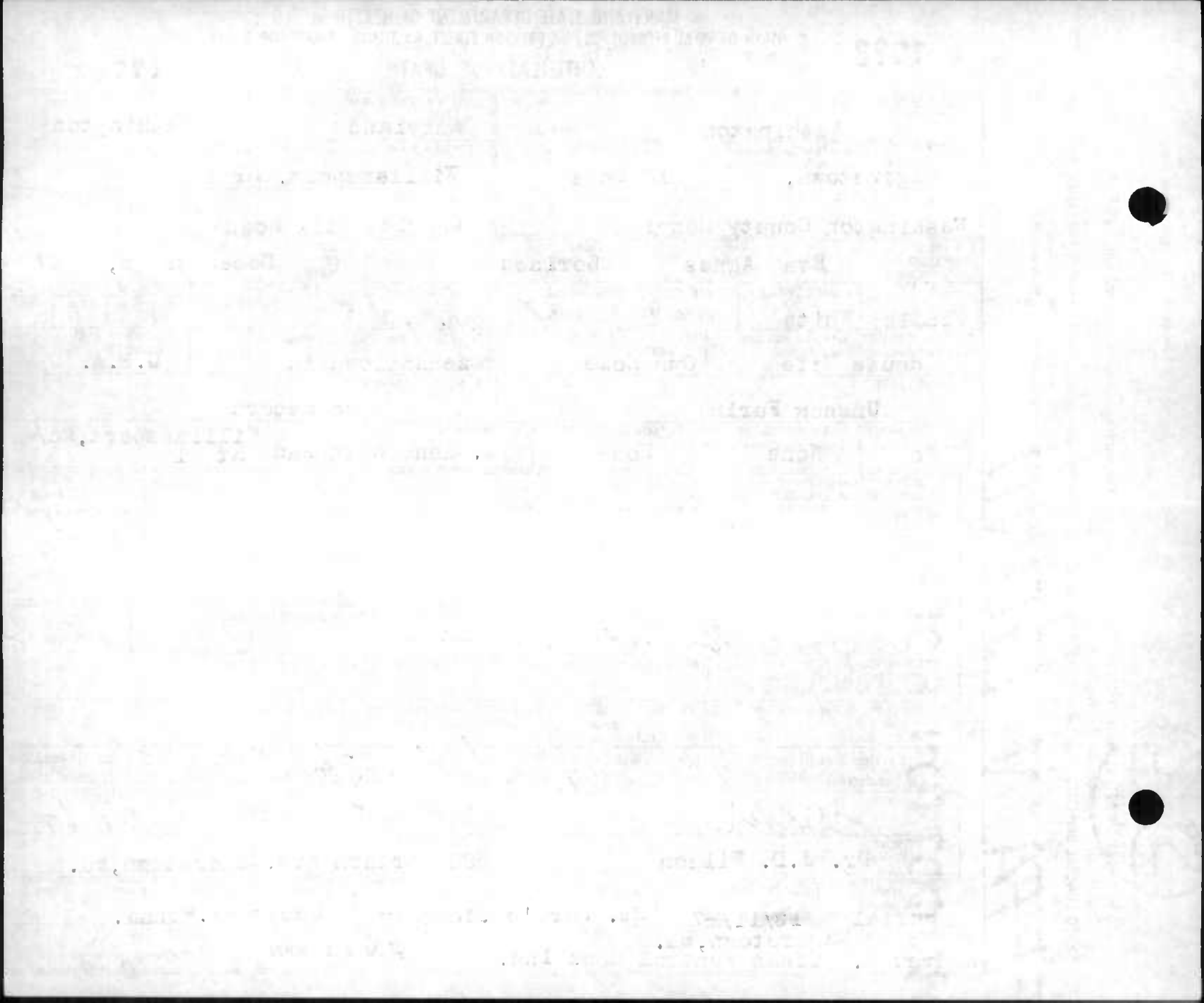
Hotel Chippewa

Hyperthermia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17737												MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items #7, 8 & 9 Film #G396 12/20/67 ph												17742											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Washington																							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown,												c. LENGTH OF STAY IN 1b 15 Days												c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport, RT#1											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital												d. STREET ADDRESS Charles Mill Road												e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Eva Middle Agnes Last Lorince												4. DATE OF DEATH Month December Day 8, Year 1967																							
5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Jan. 4, 1892				9. AGE (In years last birthday) 75 yrs.				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife								10b. KIND OF BUSINESS OR INDUSTRY Own Home								11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia								12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Unknown Furin												14. MOTHER'S MAIDEN NAME No Record																							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None												16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs. Anna Harshman Williamsport, Md/ RT #1																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyperthermia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CVA. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 2 days 2 wks.																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Probable Diabetic Mellitus												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																							
21. I certify that (I) (this hospital) attended the deceased from 1 Dec, 1967 , to 8 Dec, 1967 , that (I) was last saw the deceased alive on 7 Dec, 1967 , and that death occurred 0430 M. from causes and on the date stated above.												22b. DATE SIGNED 1/4/8/67																							
22a. SIGNATURE J.D. Wilson												22c. PHYSICIAN'S NAME (Type) Dr. J.D. Wilson												22d. ADDRESS 580 Northrn Ave. Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/11/67				23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery				23d. LOCATION (City or Town) (County) (State) Lectrone, Penna.																							
24. FUNERAL DIRECTOR Hagerstown, Md. Andrew K. Coffman Funeral Home Inc.												25a. REC'D BY REGISTRAR DEC 11 1967				25b. REGISTRAR'S SIGNATURE [Signature]																			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17738

17743

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 1707 Woodcrest Road			
3. NAME OF DECEASED (Type or print) First ATLEE Middle FRANKLIN Last MAC DONALD				4. DATE OF DEATH Month Dec Day 6 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 30 1893		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice Pres P.E.C.		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Bad Axe Huron Co Mich.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archie T. Mac Donald				14. MOTHER'S MAIDEN NAME Amelia J. Frank			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-9474		17. INFORMANT Address Mrs Dorothy A Mac Donald			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary heart disease (c) 11 years -				1907 Woodcrest Road Hagerstown Md		INTERVAL BETWEEN ONSET AND DEATH 3 days -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/12, 1938 , to 12-6, 1967 that (I) (we) last saw the deceased alive on 12-6, 1967 , and that death occurred at 9:4 M, from causes and on the date stated above.							
22a. SIGNATURE John H. Hornbaker				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12:6:67	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				22d. ADDRESS 154 West Washington St., Hagerstown, Md. 21740			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12/7/67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR DATE DEC 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1474

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. Va. b. COUNTY Lincoln	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 weeks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 854 View St.		d. STREET ADDRESS RFD 1	
3. NAME OF DECEASED (Type or print) First Elma Middle Edith Last Madden		4. DATE OF DEATH Month December Day 29 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-03
9. AGE (In years at birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Hamlin, W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry R. Lucas		14. MOTHER'S MAIDEN NAME Nola Forshie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Lorenza Madden, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Auricular flutter DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Indefinite		INTERVAL BETWEEN ONSET AND DEATH Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12-26-67 , 19 67 , to death , 19 67 , that (I) (we) last saw the deceased alive on 12-27 1967 , and that death occurred at 6A M, from causes on and on the date stated above.			
22a. SIGNATURE Robert F. Keagle M.D.		22b. DATE SIGNED 12-29-67	
22c. PHYSICIAN'S NAME (Type) Robert F. Keagle		22d. ADDRESS Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-31-67	23c. NAME OF CEMETERY OR CREMATORY Madden Cemetery	23d. LOCATION (City or Town) (County) (State) Hamlin, W. Va.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JAN 2 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

107596

17744

CERTIFICATE OF DEATH

Washington

Washington

October 21, 1941

October 21, 1941

Washington

Washington

Female, White

Washington, D.C.

Washington, D.C.

Henry A. Jones

Thomas Robert Jones, Washington, D.C.

NO

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Washington" and "October" are visible.]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 516 MECHANIC ST. CUMBERLAND d. STREET ADDRESS 516 MECHANIC ST e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth Pearl Malone First Middle Last		4. DATE OF DEATH Dec 13 1967 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1901 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work Theatre		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Long, Richard W.		14. MOTHER'S MAIDEN NAME DARR, SARAH ELIZABETH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-14-6992 17. INFORMANT ALVIN H. MALONE, 516 MECHANIC ST. Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERNEPHROMA WITH METASTASIS 180 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 4 , 19 67 , to Dec 13 , 19 67 , that (I) (we) last saw the deceased alive on Dec 13 , 19 67 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE FE. U. PORCINCULA 22c. PHYSICIAN'S NAME (Type) FE. U. PORCINCULA		22b. DATE SIGNED Dec 14, 1967 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. ADDRESS WESTERN MARYLAND STATE Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/17/67	23c. NAME OF CEMETERY OR CREMATORY Sun set Memorial Park	23d. LOCATION (City, town or county) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 18 1967 25b. REGISTRAR'S SIGNATURE John Charles Judge	

CENTRALITY OF DEATH

1971

Rm Pearl Malone Dec 13 67

Dec 13 67 Dec 4 67 Dec 11 67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE West Virginia b. COUNTY Hampshire	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Romney	
c. LENGTH OF STAY IN 1b 1 year		d. STREET ADDRESS 376 Key Circle	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 376 Key Circle		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha Elizabeth Manning		4. DATE OF DEATH Month December Day 19 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1918
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 13 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Hampshire County, W. Va.	
11. BIRTHPLACE (County & State, or foreign country) Hampshire County, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James E. Beatty		14. MOTHER'S MAIDEN NAME Jennie E. Carter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Ollie Marie Beatty (sister)		Address 376 Key Circle Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma, 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) pharynx with metastasis to mediastinum and DUE TO (c) right lung			INTERVAL BETWEEN ONSET AND DEATH 13 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from November , 19 66 , to December , 19 67 , that (I) (we) last saw the deceased alive on Dec. 12 , 19 67 , and that death occurred at 11:55 AM from causes and on the date stated above.			
22a. SIGNATURE John H. Kehne, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John H. Kehne, M.D.		22d. ADDRESS 1229 Ravenwood Hgts., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-21-67	23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	23d. LOCATION (City or Town) (County) (State) Romney, W. Va.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 21 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
Item #13 a,b,c,d & e prior, taken from birth cert.												
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Marshall						12 Month 22 Day 67 Year			1:11 PM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		12-22-67					MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland							Washington County Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown			Washington County Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.			Wash.		Hagerstown				204 Hager			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
First Middle Last			First Middle Last									
Robert L. Marshall			Judy Carolyn McAfee									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
Yes, na, ar, unknown						Medical Record						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Primary respiratory failure												
7735 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
(b) Immaturity												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED			
George Jennings, M. D.									1/2/68			
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS									
George Jennings, M. D.			318 N. Potomac St., Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
JANUARY 9, 1968			WASHINGTON COUNTY HOSPITAL		HAGERSTOWN, MARYLAND							
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
John Schoffer, Adm.			Wash Co Hosp.			DATE JAN 10 1968			Charles Judge			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

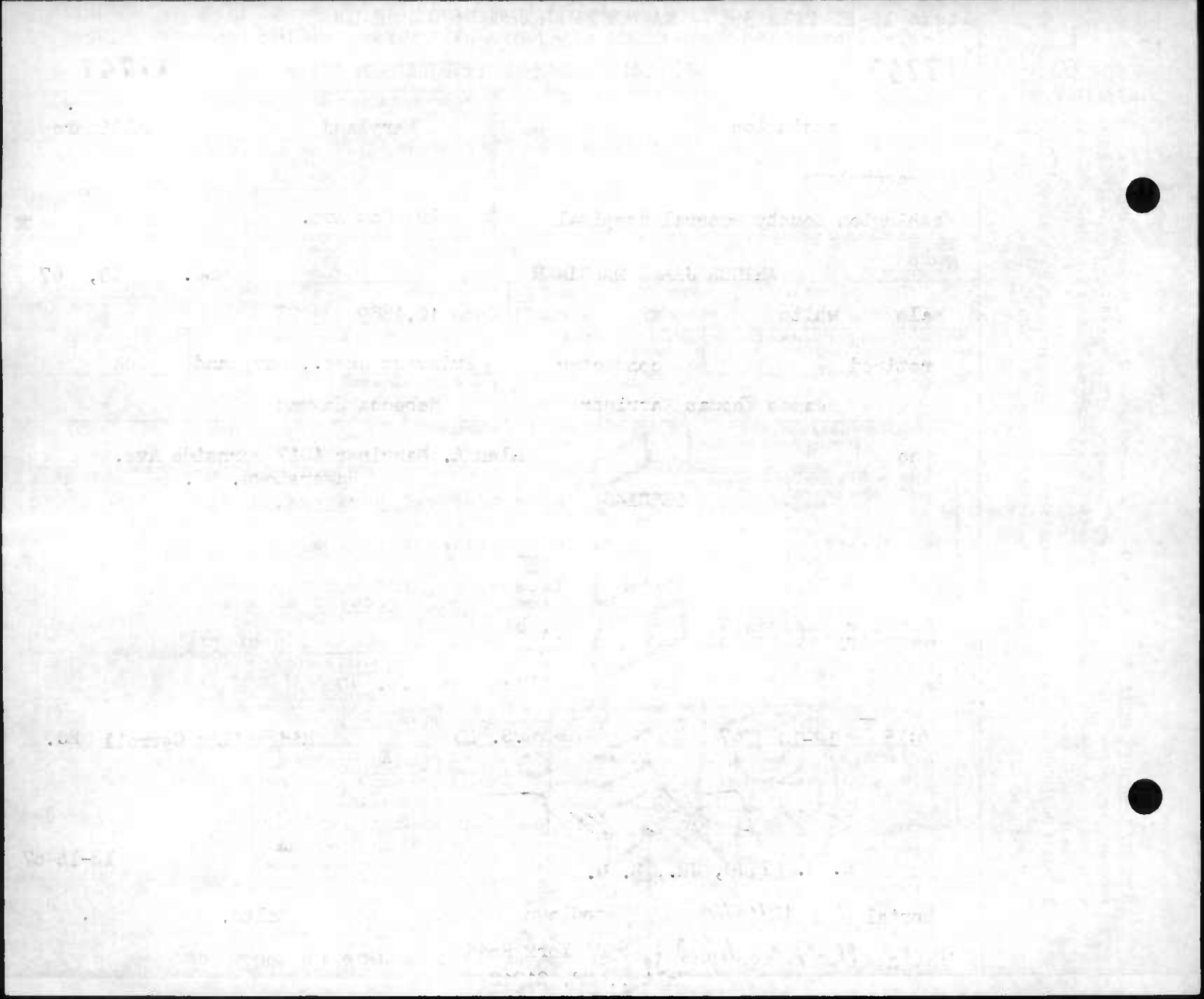
17747

FOR STATE HEALTH DEPT

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County General Hospital		d. STREET ADDRESS 203 Oak Ave.	
3. NAME OF DECEASED (Type or print) ARTHUR JAMES MARRINER		4. DATE OF DEATH Month DEC. Day 13, Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1889
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY conductor	
11. BIRTHPLACE (State or foreign country) Princess Anne., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Thomas Marriner		14. MOTHER'S MAIDEN NAME Rebecca Hayman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Alan A. Marriner		Address 1817 Burnside Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEADING/ Acute subdural hematoma, left 825.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral congestion and edema DUE TO (c) Cerebral laceration, inferior surface, left occipital lobe		INTERVAL BETWEEN ONSET AND DEATH 74 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobular pneumonia, lower lobes, bilateral Coronary atherosclerosis, severe, with old occlusion of right coronary		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) In auto accident on U.S. 40	
20c. TIME OF INJURY Month, Day, Year Hour 6:15 p.m. 12-10 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work U.S. 40	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ridgeville Carroll Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE E. W. DITTO, JR., M. D.		22. DATE SIGNED 12-14-67	
EXAMINER'S NAME (Type) E. W. DITTO, JR., M. D.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 12/16/67	23c. NAME OF CEMETERY OR CREMATORY Woodlawn	23d. LOCATION (City or Town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR Mitchell Wiskefeld		ADDRESS 6500 York Road	
25a. REC'D BY REGISTRAR DATE DEC 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



17744

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

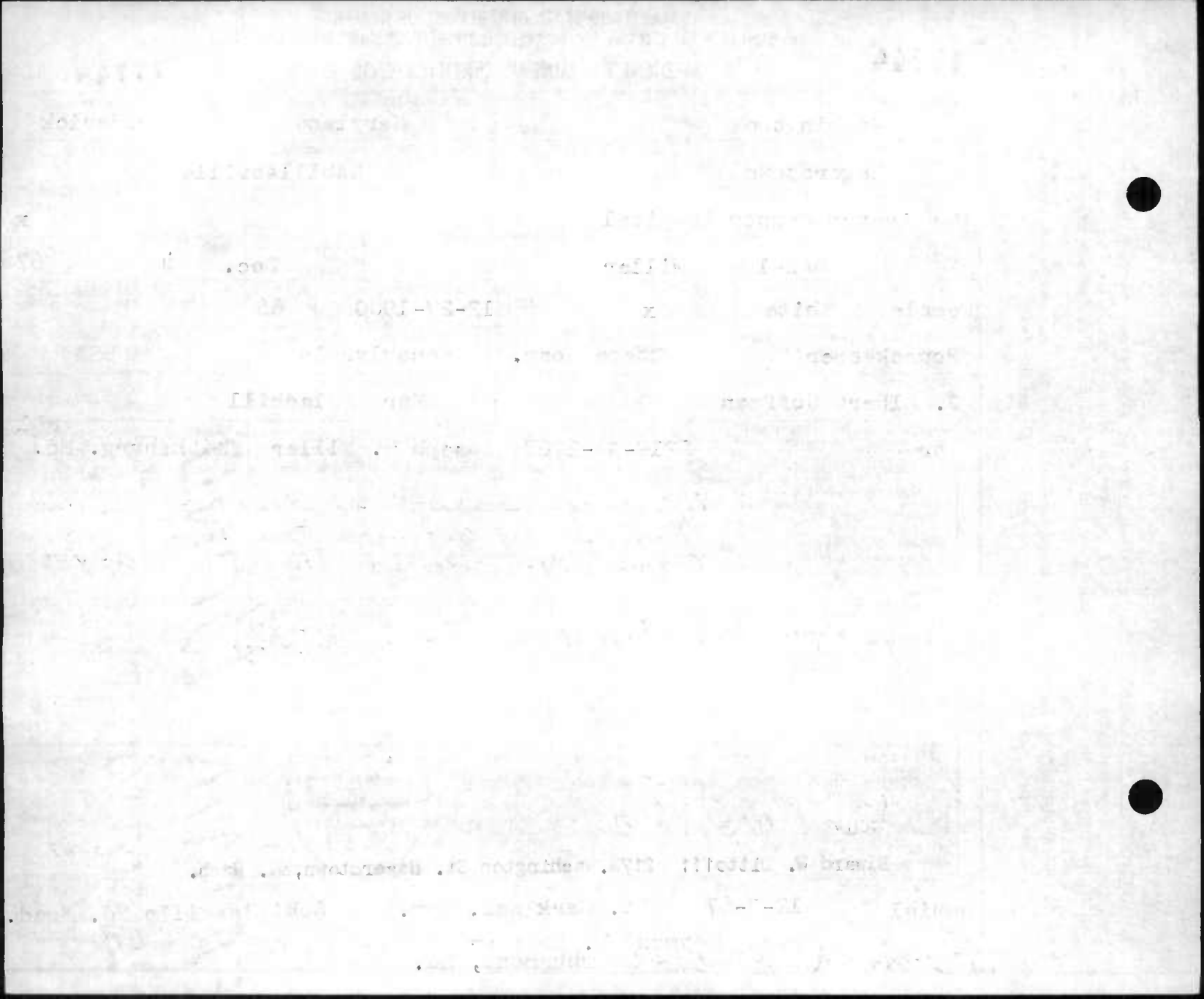
17744

FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sabillasville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 102	
3. NAME OF DECEASED (Type or print) Hazel Miller		4. DATE OF DEATH Month Dec. Day 4 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-1900
9. AGE (In years last birthday) 66		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY State Hosp.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME J. Albert Coffman		14. MOTHER'S MAIDEN NAME Mary Gladhill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-36-2707	
17. INFORMANT Joseph W. Miller		Address Smithsburg. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Massive - 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Posterior and Anterior - Due to - DUE TO (c) Coronary Atherosclerosis, Severe		INTERVAL BETWEEN ONSET AND DEATH 30 hrs 25 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) Benign Nephrosclerosis, cholelithiasis, Ac. Hemorrhagic Duodenopathy		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 12-5-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-7-67	
23c. NAME OF CEMETERY OR CREMATORY St. Mark Ref. Cem.		23d. LOCATION (City or Town) (County) (State) Sabillasville Md. Fred.	
24. FUNERAL DIRECTOR Raymond E. Creager		25a. REC'D BY REGISTRAR DEC 11 1967	
ADDRESS Thurmont, Md.		25b. REGISTRAR'S SIGNATURE Charles J. ...	



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

17745

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17749

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN IB LIFE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 428 MINERAL AVE.			
3. NAME OF DECEASED (Type or print) First JAMES Middle FREDERICK Last MOATS				4. DATE OF DEATH Month DECEMBER Day 7 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/22/1944	
				9. AGE (In years by birthday) 23 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION WORK			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME RAYMOND R. MOATS				14. MOTHER'S MAIDEN NAME EDITH SHAFFER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-42-2942		17. INFORMANT MR. RAYMOND E. MOATS Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gunshot wound head - with DUE TO (b) Extensive hemorrhage + DUE TO (c) Laceration Brain							INTERVAL BETWEEN ONSET AND DEATH 4 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound			
20c. TIME OF INJURY Month, Day, Year Hour 11:35 a.m. Dec 5, 19 67 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
				20f. (City or town) Hagerstown Wash		(County) MD (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto, III, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.				22. DATE SIGNED 12/8/67 Address (Street, city, town, or county) 217 W. Washington St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/9/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City or town) (County) (State) HAGERSTOWN WASH. MD.	
24. FUNERAL DIRECTOR W. J. Harment, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE DEC 13 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>24 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>10 Redwood St.</u>	
3. NAME OF DECEASED (Type or print) <u>Robert R. Monn</u>		4. DATE OF DEATH <u>Dec. 5, 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-8-26</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lky. Army Depot</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Norman S. Monn</u>		14. MOTHER'S MAIDEN NAME <u>Elven Over</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. II</u>	
17. INFORMANT <u>Mrs. Betty Over</u>		Address <u>10 Redwood St. Chambersburg, Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Skull Fractures with</u> DUE TO <u>Brain Stem Injury and Multiple</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lacerations Brain</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of truck - struck by WMAR Train</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:00 p.m. Dec 4, 1967</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Chambersburg</u> (County) <u>Franklin</u> (State) <u>Pa.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>		22. DATE SIGNED <u>12-6-67</u>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto III</u>		23. NAME OF CEMETERY OR CREMATORY <u>Norland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-9-67</u>	
24. FUNERAL DIRECTOR <u>Robert R. Barlowe</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Chambersburg, Pa.</u>		26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 8 1967</u>			

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(English, French, etc.) in accordance with the instructions of the

You

CERTIFICATE OF DEATH

17751

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garlock Mem. Convalescent Hospital		d. STREET ADDRESS 2 S. Vermont Street	
3. NAME OF DECEASED (Type or print) First Joseph Middle Emmanuel Last Morgan Sr.		4. DATE OF DEATH Month Dec. Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1898
9. AGE (In years) 69 yrs.		10. IF UNDER 1 YEAR Months 1 Days 21 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Homes	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Oscar Morgan		14. MOTHER'S MAIDEN NAME Annie Rohrer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-9254	
17. INFORMANT Mrs. Charles Payne Jr.		Address Williamsport, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 14 hrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (1) this hospital attended the deceased from Jan 1959 to Dec. 28, 1967 , that (2) (we) last saw the deceased alive on Dec 28 1967 , and that death occurred at 6:30 PM , from causes and on the date stated above.			
22a. SIGNATURE M.E. Byrkit		22b. DATE SIGNED 12-31-67	
22c. PHYSICIAN'S NAME (Type) M.E. Byrkit		22d. ADDRESS Williamsport Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 2, 1968	23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Williamsport, Wash., Md.
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Md.		25a. REC'D BY REGISTRAR DATE JAN 2 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>			d. STREET ADDRESS <u>201 E. Franklin St.</u>		
3. NAME OF DECEASED (Type or print) First <u>Clayton</u> Middle <u>Wm</u> Last <u>Morrison</u>			4. DATE OF DEATH Month <u>December</u> Day <u>15</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1912</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Goodwill Industries</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carlisle, Penna.</u>	
13. FATHER'S NAME <u>Charles Everhart Morrison</u>			14. MOTHER'S MAIDEN NAME <u>Minnie Florence Behrens</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. W.W. Clem</u> Address <u>428 Jefferson St. Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cere arteritis nodosa</u> <u>456 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/27</u> , 19 <u>67</u> to <u>12/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>12/14</u> , 19 <u>67</u> , and that death occurred at <u>5:15 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>George Jennings</u>			22b. DATE SIGNED <u>12/18/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>George Jennings</u>			22d. ADDRESS <u>318 N. Potomac St. Hagerstown, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/17/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md</u>	
24. FUNERAL DIRECTOR <u>Wm. A. Horst</u>		ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 19 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>

1975

STATE OF NEW YORK

IN SENATE
January 15, 1975

REPORT OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS

FOR THE YEAR
ENDING DECEMBER
31, 1974

Wm. C. Hunt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Williamsport RFD #2 d. STREET ADDRESS Williamsport RFD #2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DANIEL Middle ELSWORTH Last MOWEN		4. DATE OF DEATH Month Dec. Day 13 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm	9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR: Months 7 Days 26 Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Wilson Dist. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Martin O. Mowen		14. MOTHER'S MAIDEN NAME Alice Carbaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) -----		16. SOCIAL SECURITY NO. 220-34-0747-A	
17. INFORMANT Mrs. Joseph Thomas Jr. Boonsboro Md.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia DUE TO nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 mo. 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-1 67 , 19 67 , to 12-13 , 19 67 , that (I) (we) last saw the deceased alive on 12-13 , 19 67 , and that death occurred at 6:10 PM , from the causes and on the date stated above.			
22a. SIGNATURE Joseph G. Crisp M.D.		22b. DATE SIGNED 	
22c. PHYSICIAN'S NAME (Type) J.C. CRISP		22d. ADDRESS Hagerstown Ind.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 17-67	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town or county) Wash (State) Williamsport Md.	
24. FUNERAL DIRECTOR Mr. A. bert. L. Leaf		25a. REC'D BY REGISTRAR DEC 18 1967	
ADDRESS Williamsport Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Handwritten signature: J. C. Cray
11-1-1911

Handwritten signature: J. C. Cray

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Alice Cray

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17750

17754

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>WASH.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b —			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>329 Daycotah Ave.</u>			d. STREET ADDRESS <u>329 DAYCOTAH AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>CHARLES WALTER MYERS</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>2/25/1920</u>		9. AGE (In years last birthday) <u>47</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Antietam Motors, Inc.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			13. FATHER'S NAME <u>Walter B. Myers</u>		
14. MOTHER'S MAIDEN NAME <u>Catharine Casey</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes give war or dates of service)		
16. SOCIAL SECURITY NO. <u>165-10-9700</u>			17. INFORMANT <u>Mildred E. Myers - Hagerstown</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) —					INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>1 1/2 yrs -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour "o.m." <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>6/9, 1966</u> , to <u>12/29, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/27/1967</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>John H. Hornbaker</u>			22b. DATE SIGNED <u>12-29-67</u>		22c. PHYSICIAN'S NAME (Type) <u>JOHN H. HORNBAKER, M.D.</u>
22d. ADDRESS <u>154 W. WASHINGTON, HAGERSTOWN, Md. 21740</u>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>	23b. DATE THEREOF <u>12/31/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Park near Hagerstown, Md.</u>	23d. LOCATION (City or Town)	(County)	(State)
24. FUNERAL DIRECTOR <u>A. E. Munnich - Greencastle, Pa.</u>			25a. REC'D BY REGISTRAR DATE <u>JAN 2 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17751

17755

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 189 W. MAIN STREET		d. STREET ADDRESS 189 W. MAIN STREET	
3. NAME OF DECEASED (Type or print) First Middle Last KITTIE WILHAMENIA MYERS		4. DATE OF DEATH Month Day Year DECEMBER 1 1967	
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/1897
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY HIGH SCHOOL CAFEATER	
11. BIRTHPLACE (County & State, or foreign country) FULTON CO., M. PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES B. WEAVER		14. MOTHER'S MAIDEN NAME MARY CATHERINE SENSEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. FRED TRUAX		Address 13 FUNK AVENUE HANCOCK, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) 4201 DUE TO (c) Interval between onset and death 1 hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/1/67 , 19__, to 12/1/67 , 19__, that (I) (we) last saw the deceased alive on 12/1/67 , 19__, and that death occurred at 4:55 A.M. from causes and on the date stated above.			
22a. SIGNATURE FB Thomas III M.D.		22b. DATE SIGNED 12/2/67	
22c. PHYSICIAN'S NAME (Type) FB Thomas III M.D.		22d. ADDRESS HANCOCK, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12/4/67	23c. NAME OF CEMETERY OR CREMATORY TONOLOWAY BAPTIST	23d. LOCATION (City or Town) (County) (State) HANCOCK, FULTON CO., PENNA.
24. FUNERAL DIRECTOR Howard J. Shaw Hancock, Md.		25a. REC'D BY REGISTRAR DATE DEC 6 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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CHARLES S. WEAVER

MARY CATHERINE SENEAL

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MRS. FRED TRUAX, HANCOCK, MARYLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearspring		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 31 Main Street		d. STREET ADDRESS 31 Main Street	
3. NAME OF DECEASED (Type or print) First Bertie Middle Virginia Last Newlin		4. DATE OF DEATH Month Dec. Day 10 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27 1889
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 8 Days 12 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Mt. Falls Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME (Unknown) Brill		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-18-2194A	
17. INFORMANT Mrs. Laura O. Lowman		18. ADDRESS 31 Main Street Clearspring Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic Heart Disease 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential Hypertension DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH many years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Clear Spring	
21. I certify that (I) (this hospital) attended the deceased from 10/24/66 , 19 66 , to 11/14 , 19 67 , that (I) (we) last saw the deceased alive on 11/14 , 19 67 , and that death occurred at 8:30 AM , from causes and on the date stated above.			
22a. SIGNATURE P. Mandell		22b. DATE SIGNED 12/11/67	
22c. PHYSICIAN'S NAME (Type) A.M. Mandell MD.		22d. ADDRESS 301 E. ANTIETAM ST.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 12-67	23c. NAME OF CEMETERY OR CREMATORY Gardens Cedar Lawn Memorial	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md.
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.		25a. REC'D BY REGISTRAR DEC 13 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

1755

REPORT OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 12 Hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro d. STREET ADDRESS 315 N. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Naomi Pauline Nunamaker First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 31, 1889 9. AGE (In years last birthday) 78 yrs. 10. IF UNDER 1 YEAR Months 4 Days 26 11. IF UNDER 24 HRS. Hours 4 Min. 26				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Keedysville, Md. 12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John R. Nunamaker 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. 16. SOCIAL SECURITY NO. 219-54-0952 17. INFORMANT Mrs. Kleora Early, 315 N. Main St.				14. MOTHER'S MAIDEN NAME Susan K. Pry 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 12 hours 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____				21. I certify that (I) (this hospital) attended the deceased from Oct 1 , 19 59 , to Dec 27 , 19 67 , that (I) (we) last saw the deceased alive on Dec 27 , 19 67 , and that death occurred at 5:50 PM , from causes and on the date stated above. 22a. SIGNATURE <i>Joseph Secordari</i> 22b. DATE SIGNED 12-29-67 22c. PHYSICIAN'S NAME (Type) JOSEPH SECORDARI 22d. ADDRESS Boonsboro Md 21713			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12-30-67 23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery 23d. LOCATION (City or Town) (County) (State) Keedysville, Md.				24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md 25a. REC'D BY REGISTRAR JAN 2 1968 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Washington County Hospital

12 Hours

112 N. Main St.

December 27

July 31 1889

U. S. A.

Boonshoro, Md.

112 N. Main St.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17758

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>24 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>25 1/2 W. Franklin St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Albert</u> Last <u>Ponton</u>				4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>19 67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1923</u>		9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carnival Rides</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry L. Ponton</u>				14. MOTHER'S MAIDEN NAME <u>Susie Americus Barrett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-16-3526</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mrs. Susie A. Ponton 25 1/2 W. Franklin St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis (Cardiac arrest)</u> DUE TO <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>Year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>13 Dec 1967</u> , to <u>13 Dec 1967</u> , that (I) (we) last saw the deceased alive on <u>13 Dec 1967</u> , and that death occurred at <u>5 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>J.D. Wilson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.D. Wilson M.D.</u>				22d. ADDRESS <u>580 Northern Ave. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/16/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown- Washington-Md</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1000. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>11 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>460 McDowell Ave.</u>		d. STREET ADDRESS <u>460 McDowell Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Milton</u> Last <u>Price</u>		4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1897</u>
9. AGE (In years last birthday) <u>70</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical Parts</u>	
11. BIRTHPLACE (State or foreign country) <u>Luray, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Price</u>		14. MOTHER'S MAIDEN NAME <u>Jenkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-4996</u>	
17. INFORMANT <u>Mrs. Lillian Price</u>		Address <u>Hagerstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis right coronary artery</u> DUE TO (b) <u>Coronary atherosclerosis, severe</u> DUE TO (c) <u>20 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>pyelonephritis, aneurysm abdominal aorta, cholelithiasis</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward W. Ditto, III</u> M.D.		22. DATE SIGNED <u>12-27-67</u>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>217 W. Wash. St. Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/29/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. G. Hunt</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 29 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>William G. Judge</u>			

Wm. C. Hunt

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 17 Public Square	
3. NAME OF DECEASED (Type or print) Wilda Puffenberger		4. DATE OF DEATH December 18 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3.3.1916
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) GREAT CAPON W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W MC GOWN		14. MOTHER'S MAIDEN NAME MINNIE EVERSOLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT KEITH PUFFENBARER 311 NORTH ST. MD		Address MAUGENSVILLE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 3221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) malnutrition & Liver Failure 2 weeks DUE TO (c) Acute & Chronic Alcoholism		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-21 1967 , to 12-15 1967 , that (I) (we) last saw the deceased alive on Dec. 15 1967 , and that death occurred at 12-15 1967 , M, from causes and on the date stated above.			
22a. SIGNATURE Charles R. Wiener M.D.		22b. DATE SIGNED 12-20-67	
22c. PHYSICIAN'S NAME (Type) Charles R. Wiener		22d. ADDRESS Box 173, Myersville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 12.21.67	23c. NAME OF CEMETERY OR CREMATORY GREAT CAPON	23d. LOCATION (City or Town) (County) (State) GREAT CAPON MORGAN W.VA.
24. FUNERAL DIRECTOR Howard F. Stone Hancock Md		25a. REC'D BY REGISTRAR DEC 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

44-38861

INVESTIGATION REPORT

1/10/68

MEMPHIS, TENN.

RE: MARTIN LUTHER KING, JR.
MURDER

JOHN W. COOK

JOHN W. COOK

JOHN W. COOK

1/10/68

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 6 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Avalon Manor Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown d. STREET ADDRESS 218 East Baltimore St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Fred David Renner			4. DATE OF DEATH Month December Day 11 Year 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1898	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 7 Days 11		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Manager		10b. KIND OF BUSINESS OR INDUSTRY Dairy	11. BIRTHPLACE (County & State, or foreign country) Boonsboro, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Richard L. Renner			14. MOTHER'S MAIDEN NAME Emma E. Line				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-01-1059	17. INFORMANT Mrs. Maude E. Renner, 218 E. Baltimore St., Funkstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Car Accident DUE TO Excessive Dr. Medication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Excessive Dr. Medication DUE TO (c) Excessive Dr. Medication PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia					INTERVAL BETWEEN ONSET AND DEATH 1 year		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 6-7 , 19 66 , to Dec 10 , 19 67 that (I) (we) last saw the deceased alive on Dec 10 , 19 67 , and that death occurred at 3:15 AM , from causes and on the date stated above.							
22a. SIGNATURE E. R. Hardizahor			22b. DATE SIGNED 12-11-67				
22c. PHYSICIAN'S NAME (Type) E. R. Hardizahor			22d. ADDRESS 310 N. Potomac Road, Funkstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-13-67	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro, Maryland				
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.			25a. REC'D BY REGISTRAR DEC 15 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

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1175

STATEMENT OF DEATH

Washington, Maryland

Deceased

Age 28 years

Dec 28, 1952

John F. Kennedy

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17759

17763

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN 1b 15 Yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 101 Reynolds Ave West				d. STREET ADDRESS 101 Reynolds Road West			
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND GROSH ROBISON				4. DATE OF DEATH Month Day Year Dec 15 1967 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 22 1909	9. AGE (In years lost birthday) yrs. 58	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) W. Md. R.R.		10b. KIND OF BUSINESS OR INDUSTRY Record Office		11. BIRTHPLACE (County & State, or foreign country) Md. Clear Spring Wash Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry E. Robison				14. MOTHER'S MAIDEN NAME Laura V. Grosh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-7508		17. INFORMANT Mrs Miriam R. Robison Tammany Manor			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Congestive failure DUE TO (b) Atherosclerotic cardiovascular disease DUE TO (c) 10 yrs				INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) No				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from Jan , 19 60 , to Dec 14 , 19 67 , that (b) (we) last saw the deceased alive on Dec 7 , 19 67 , and that death occurred at 11:07 M, from causes and on the date stated above.							
22a. SIGNATURE M.E. Byrkit				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) M.E. Byrkit	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/16/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR DEC 21 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

100-100000

CONFIDENTIAL - SECURITY INFORMATION

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Avalon Manor Nursing Home		d. STREET ADDRESS 105 W. Main St.	
3. NAME OF DECEASED (Type or print) First Margaret Middle Anne Last Roulette		4. DATE OF DEATH Month Dec. Day 4 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3 1883
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months 4 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John D. Roulette		14. MOTHER'S MAIDEN NAME Anna Rohrback	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215 36 7260	
17. INFORMANT Mr. John Roulette		122 W. Main St. Sharpsburg Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X MITRAL INSUFFICIENCY & STENOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RHEUMATIC HEART DISEASE DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH OVER 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS, SENILETY & DEBILITY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/28/66 19 66 , to 12/4 19 67 , that (I) was lost saw the deceased alive on 12/26 19 67 , and that death occurred at 10:30 M, from causes on and on the date stated above.			
22a. SIGNATURE R. Amarillo		22b. DATE SIGNED 12/6/67	
22c. PHYSICIAN'S NAME (Type) R. Amarillo M.D.		22d. ADDRESS Sharpsburg Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 7 1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or town) (County) (State) Sharpsburg Washington Md.	
24. FUNERAL DIRECTOR Albert L.. Leaf Williamsport Maryland		25a. REC'D BY REGISTRAR DEC 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

WILSON, J. R. 1963. J. R. WILSON, JR.

HEALTHY TRAIN VITAMIN

MITCHELL INVESTMENTS & STEEL

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17761

17765

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 2 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Springs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Williamsport Sanatorium				d. STREET ADDRESS R #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STEPHEN C SANDALA				4. DATE OF DEATH Month December Day 25 Year 19 67			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct 14 1893		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Westmoreland Co Greensburg Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No Record				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. W.W.#1 201-865-5785		17. INFORMANT Mr Ray Tabler 1240 Glenwood Ave Hagerstown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Vascular Disease, Severe DUE TO (c) Hemiplegia						INTERVAL BETWEEN ONSET AND DEATH 4 days 5 years 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 28, 1965 , to Dec. 25, 1967 , that (I) (we) last saw the deceased alive on Dec. 25, 1967 , and that death occurred at 5:55 P.M. from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-26-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.				22d. ADDRESS 215 W. Washington St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/29/67		23c. NAME OF CEMETERY OR CREMATORY Crest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Clifton Passaic Co N.J.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR DATE DEC 28 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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16

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17762

17766

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			c. LENGTH OF STAY IN 1b <u>6 yrs-2 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waynesboro</u> <u>75.3</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Homewood Church Home</u>				d. STREET ADDRESS <u>135 N Grant</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Elizabeth</u> Last <u>Sheldon</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1883</u>		9. AGE (In years last birthday) <u>84</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rouzeville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Theodore Whitmore</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Kriner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>173-03-1021D</u>		17. INFORMANT <u>Mark E. Wagner</u> Address <u>2750 Va. Ave Williamsport, Md 21785</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive CV Dis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>8 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 15, 1965</u> to <u>Dec 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>12-5-1967</u> , and that death occurred at <u>1:50 A.M.</u> from causes and on the date stated above.							
22a. SIGNATURE <u>Robert P. Connor</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-6-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Connor</u>				22d. ADDRESS <u>137 W. Washington Hagerstown, Md. 21774</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Waynesboro Franklin Pa</u>	
24. FUNERAL DIRECTOR <u>Walter Z. Grove, Waynesboro Pa.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 7 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

1-158

STATE OF OHIO

1-158

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2½ years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 59 Broadway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anne Middle Piper Last Shoop		4. DATE OF DEATH Month December Day 3 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-97
9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hostess 10b. KIND OF BUSINESS OR INDUSTRY hotels	
11. BIRTHPLACE (County & State, or foreign country) Sharpsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Irwin		14. MOTHER'S MAIDEN NAME Laughty Piper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-09-2218A	
17. INFORMANT John Hollyday, Hagerstown, Md.		18. ADDRESS	
18a. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage, intracerebral 330x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of cerebral vascular aneurysm DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Nov. 27 , 19 67 , to Dec. 3 , 19 67 , that (I) (we) last saw the deceased alive on Dec. 2 , 19 67 , and that death occurred at 6:30 A. M, from causes and on the date stated above.	
22a. SIGNATURE B. B. Kneisley		22b. DATE SIGNED 12/4/67	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE THEREOF 12-5-67	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or Town) (County) (State) Sharpsburg, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DEC 6 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11763

RECORD OF CASE

11763

Washington

2-2-27

Washington

Washington County, Maryland

2-2-27

Place

Shop

Anna

White

2-2-27

Hotel

Shirley, Md.

John Lewis

Shirley, Md.

215-00-22184 John Holroyd, Washington, Md.

215-00-22184 John Holroyd, Washington, Md.

215-00-22184 John Holroyd, Washington, Md.

215-00-22184 John Holroyd, Washington, Md.

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215-00-22184 John Holroyd, Washington, Md.

215-00-22184 John Holroyd, Washington, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
17764											
17768											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>21.1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>						d. STREET ADDRESS <u>443 N. Jonathan Street</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Boy Smith</u>						4. DATE OF DEATH Month Day Year <u>Dec 25 1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 24 1967</u>		9. AGE (In years lost birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown Md.</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Willie Garner</u>						14. MOTHER'S MAIDEN NAME <u>Marilyn Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mariilyn Smith 443 N. Jonathan St.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FEM ATELECTASIS</u> <u>7625</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity.</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> , 19 <u>67</u> , to <u>12/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>25 Dec.</u> 19 <u>67</u> , and that death occurred at <u>2:45</u> AM, from causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-27-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>W.H. Finner</u>						22d. ADDRESS <u>218 N. Potomac St. Hagerstown Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-28-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Md.</u>			
24. FUNERAL DIRECTOR <u>John R Watson Jr. Hagerstown Md.</u>						25a. REC'D BY REGISTRAR DATE <u>DEC 29 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

7-285201

1178

REPORT OF STATE

1178

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 52 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 720 Virginia Ave.		d. STREET ADDRESS 720 Virginia Ave.	
3. NAME OF DECEASED (Type or print) First Clyde Middle Hower Last Sowers		4. DATE OF DEATH Month December Day 22 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-74
9. AGE (In years last birthday) yrs. 93		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) millar		10b. KIND OF BUSINESS OR INDUSTRY flour mill	
11. BIRTHPLACE (County & State, or foreign country) Big Spring, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Peter J. Sowers		14. MOTHER'S MAIDEN NAME Mary J. Knepper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-09-3036	
17. INFORMANT Mrs. Fannie Sowers, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition from Esophageal stenosis.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 12/22, 1967 , that (I) (we) last saw the deceased alive on 4/29 19 67 , and that death occurred at 10:55 AM , from causes and on the date stated above.			
22a. SIGNATURE George Jennings		22b. DATES SIGNED 12/22/67	
22c. PHYSICIAN'S NAME (Type) George Jennings		22d. ADDRESS 318 N. Potomac St Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-24-67	23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery Shippensburg, Pa.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 26 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

17752

EDWARD G. BROWN

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Washington

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Washington

22 Years

Washington

220 Virginia Ave.

220 Virginia Ave.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17766

17770

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 25 Months			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garlock Convalescent Home				d. STREET ADDRESS 29 E. Second St.			
3. NAME OF DECEASED (Type or print) First Ruth Middle Sprenkle Last Dec.				4. DATE OF DEATH Month 18 Day 19 Year 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1889	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Near Five Forks Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel W. Singer				14. MOTHER'S MAIDEN NAME Alice Garman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 209-12-8662B		17. INFORMANT Address R. Glenn Sprenkle, 204 Oller Ave., Waynesboro Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331X DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 1 1/2	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 67 , to Dec. 18 , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 19 M, from causes and on the date stated above.							
22a. SIGNATURE David R. Hess, Sr.				22b. DATE SIGNED 12/19/67		22c. PHYSICIAN'S NAME (Type) David R. Hess, Sr.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/20/67		23c. NAME OF CEMETERY OR CREMATORY Grindstone Hill		23d. LOCATION (City or Town) (County) (State) Chambersburg #5, Franklin Pa.	
24. FUNERAL DIRECTOR ADDRESS Walter J. Grove, Waynesboro Pa.				25a. REC'D BY REGISTRAR DATE DEC 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Minutes	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 816 Virginia Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy Starleper		4. DATE OF DEATH Month Day Year Dec. 24 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 24, 1967
9. AGE (In years lost birthday) 79		IF UNDER 1 YEAR Months Days Hours 53	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of year, even if retired) Baby		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Washington, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Wesley E. Starleper	
14. MOTHER'S MAIDEN NAME Helen M. Ebersole		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Wesley E. Starleper	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central Apnea DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atelectasis of lungs DUE TO (c) Prematurity (1' 3 1/2")		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 24 Dec 1967 to 24 Dec 1967 that (I) (we) last saw the deceased alive on 24 Dec 1967 and that death occurred on 24 Dec 1967 at 3:40A M, from causes and on the date stated above.			
22a. SIGNATURE Dr. J. D. Wilson		22b. DATE SIGNED 12/24/67	
22c. PHYSICIAN'S NAME (Type) Dr. J. D. Wilson		22d. ADDRESS 580 Northern Ave Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMAINS (Type) Burial		23b. DATE THEREOF Dec. 27, 1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or Town) (County) (State) Sharpsburg, Wash., Maryland	
24. FUNERAL DIRECTOR Albert L. Leaf		25a. REC'D BY REGISTRAR DATE JAN 2 1968	
ADDRESS Williamsport, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

1977

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Washington

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Washington County Hospital

Old Virginia Ave.

John F. Blalock

John F. Blalock

John F. Blalock

John F. Blalock

Washington, Maryland

John F. Blalock

John F. Blalock

Old Virginia Ave.

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John F. Blalock

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN life life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) W. Washington St.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 837 Concord St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosalie Middle NMN Last Startzman		4. DATE OF DEATH Month December Day 30 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-18
9. AGE (In years last birthday) 49		10. IF UNDER 1 YEAR Months 4 Days 9 Hours 15 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor		10b. KIND OF BUSINESS OR INDUSTRY silk mill	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Newton Startzman		14. MOTHER'S MAIDEN NAME Nellie Middlekauff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216-46-9922	
17. INFORMANT Cornelia Startzman, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Spine at T9-10 - with 8124 DUE TO transsection cord - laceration liver, Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. (b) spleen - lungs - Multiple compound lost. (c) fractures legs - arms.		INTERVAL BETWEEN ONSET AND DEATH Immed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by Auto while Crossing Street	
20c. TIME OF INJURY Month, Day, Year 2:40 p.m. 12/30/1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Hagerstown Wash Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. Edward W. Ditto, 111 217 W. Washington St.,		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 12/31/67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-3-68	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR JAN 2 1968	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN TB 30 YEARS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				d. STREET ADDRESS 224 SUMMIT AVENUE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last RALPH MARION STOLER				4. DATE OF DEATH Month Day Year DECEMBER 6, 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 17, 1911	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FORK-LIFT OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT CORP. FAIRCHILD-HILLER		11. BIRTHPLACE (County & State, or foreign country) WAYNESBORO, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RALPH REESE STOLER				14. MOTHER'S MAIDEN NAME PEARL WAGNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES W.W. II		16. SOCIAL SECURITY NO. 214-09-1596		17. INFORMANT MRS. MARGARET K. STOLER, HAGERSTOWN, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 1 year						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 17 12/9/67 - 11/2 11/67						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5-9		20f. (City or town) (County) (State) 12-6	
21. I certify that (I) (103053000) attended the deceased from 5-9 , 19 67 to 12-6 , 19 67 , that (I) (103053000) last saw the deceased alive on 12-6-67 , 19 67 , and that death occurred at 7:00 P.M. from causes and on the date stated above.							
22a. SIGNATURE E. R. IARDIZABAL				22b. DATE SIGNED DEC. 8, 1967		22c. PHYSICIAN'S NAME (Type) E. R. IARDIZABAL, M.D.	
22d. ADDRESS 300 N. POTOMAC ST. HAGERSTOWN, MD.				22e. ADDRESS 300 N. POTOMAC ST. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/9/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR DEC 11 1967		25b. REGISTRAR'S SIGNATURE Charles M. Rouzer	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rfd. 2				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro d. STREET ADDRESS Rfd. 2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elmer Allen Stone, Sr.				4. DATE OF DEATH Month Day Year December 26, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1884	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months Days 5 18	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Rural Boonsboro, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Allen M. Stone			14. MOTHER'S MAIDEN NAME Sidney Mc Bride				
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 214-36-0392		17. INFORMANT Mrs. Hattie M. Stone, Rfd. 2, Boonsboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Secondary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 1 month years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 10-1- , 1959 , to 12-25- , 1967 , that (I) (we) last saw the deceased alive on 12-25- , 1967 , and that death occurred at 3A M, from causes and on the date stated above.							
22a. SIGNATURE Joseph Secondari				22b. DATE SIGNED 12-25-1967		22c. PHYSICIAN'S NAME (Type) JOSEPH SECON DARI	
22d. ADDRESS Boonsboro Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE THEREOF 12-28-67	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Mausoleum	23d. LOCATION (City or Town) (County) (State) Boonsboro, Maryland				
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md			25a. REC'D BY REGISTRAR DEC 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 Weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS Rt. 5	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gladys Middle May Last Valentine		4. DATE OF DEATH Month December Day 12 , Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1914
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostess		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (County & State, or foreign country) Leitersburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey Snook		14. MOTHER'S MAIDEN NAME Maude Wolfe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-1658	
17. INFORMANT Mr. Joseph A. Valentine		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of the breast. DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 6 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1965 , to Dec. 12, 1967 , that (I) XX last saw the deceased alive on Dec. 12, 1967 and that death occurred at 1:50 PM , from causes and on the date stated above.			
22a. SIGNATURE Donald E. Martin		22b. DATE SIGNED 12/13/67	
22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.		22d. ADDRESS 418 N. Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-14-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		25a. REC'D BY REGISTRAR DEC 18 1967	
25b. REGISTRAR'S SIGNATURE J. J. J. J.			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17776

1. PLACE OF DEATH o. COUNTY Wash. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 55 Years		d. STREET ADDRESS 109 South Potomac St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minerva Middle Agnes Last Ward		4. DATE OF DEATH Month December Day 5 , Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1900
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Delano, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? Delano, Pennsylvania	
13. FATHER'S NAME Elmer O. Donat		14. MOTHER'S MAIDEN NAME Annie W. Stewart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Joseph S. Ward Sr. Hagerstown, Md.	
17. INFORMANT Joseph S. Ward Sr. Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary heart disease DUE TO (c) 1 year?		INTERVAL BETWEEN ONSET AND DEATH 1 year?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-30, 1967 , to 12-5, 1967 , that (I) (we) last saw the deceased alive on 12-5, 1967 , and that death occurred at 10:15 PM , from causes and on the date stated above.			
22a. SIGNATURE John H. Hombaker, M.D.		22b. DATE SIGNED 12-6-67	
22c. PHYSICIAN'S NAME (Type) John H. Hombaker, M.D.		22d. ADDRESS 154 W. Washington St., Hagerstown, Md. 21740	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-8-1967	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR ADDRESS Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 11 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

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DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN life life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 43 Red Oak Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Betty Middle Jane Last Welch		4. DATE OF DEATH Month December Day 26 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-1928
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles V. Baker		14. MOTHER'S MAIDEN NAME Evelyn P. Kann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-24-9379	
17. INFORMANT Jack Welch, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arrest 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) States Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/23, 1967 to 12/26, 1967 , that (I) (we) last saw the deceased alive on 12/26, 1967 , and that death occurred at 3:25 PM , from causes and on the date stated above.			
22a. SIGNATURE D. J. Boyer		22b. DATE SIGNED 12/27/67.	
22c. PHYSICIAN'S NAME (Type) D. J. Boyer, M.D.		22d. ADDRESS 136 N. Potomac St., Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-28-67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DEC 29 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

4-10-1941

State of Tennessee
County of Davidson

12/10/41
12/10/41
12/10/41

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY Wash. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown		c. LENGTH OF STAY IN 1b 8 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. 4		d. STREET ADDRESS R.F.D. 4	
3. NAME OF DECEASED (Type or print) First Oliver Middle Calvin Last Wilt		4. DATE OF DEATH Month December Day 5 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1915
9. AGE (In years lost birthday) yrs. 52		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10b. KIND OF BUSINESS OR INDUSTRY Cheese Mfg.	
11. BIRTHPLACE (State or foreign country) Waynesboro, Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Wilt		14. MOTHER'S MAIDEN NAME Mary A. Reese	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 215-26-2207	
17. INFORMANT Harry Wilt Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gun shot wound head 976A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Turned	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted gunshot wound - charge through mouth	
20c. TIME OF INJURY Month, Day, Year Apr 10 am Dec 5, 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Mangonsville wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto III EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		22. DATE SIGNED 217 W. Wash. St. 67 Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-8-67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DEC 11 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

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